Theological medical ethics: A virtue based approach

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THEOLOGICAL MEDICAL ETHICS: A VIRTUE-BASED APPROACH

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ABSTRACT

The Nuremberg trials ushered in a new era in which the four principles approach has become progressively the norm in Euro-American biomedical ethics, while the concepts of virtue and character become marginalized. In recent decades, the AIDS pandemic has highlighted the social aspects of health and illness, and the individualistic nature of the four principles approach proves inadequate in addressing the social causes of illness and poor health. At the global level, the promotion of the four principles approach as the universal norm can lead to the displacement of local values and customs, and the alienation of people from their cultural heritage. In this dissertation, I argue that although principles are indispensable, the virtue-based approach is more adequate in addressing these needs. The dissertation demonstrates that a virtue-based medical ethics informed by the gospel vision of healing would support models of health care that take seriously the social determinants of illness, and advocate action on behalf of the poor and the marginalized. At the global level, virtue-based medical ethics also allows the coexistence of the universal values and the local norms, and encourages cross-cultural dialogue. This dissertation develops a virtue-based medical ethics grounded in the Aristotelian teleological structure, and integrating insights obtained from the historical critical study of the healing narratives in Luke-Acts. It also provides a correlative study of the love command in Luke and the virtue of humaneness in the medical ethics of eighteenth century Vietnamese physician Hải Thượng Lãn Ông. The concluding chapter brings these elements together in a discussion of the work of the Vietnamese Catholic AIDS care network.

Some points need to be made on my approach and methodology. First, my perspective on many issues in medical ethics has been shaped, to a significant extent, by my own experience as a physician who worked in Australia and Timor Leste. My primary concern in this dissertation is the role of the physician, and more specifically, the role of the Christian physician in the world of health care. In the following chapters, I defend the view that in today's context, especially in the fight against the AIDS pandemic, physicians not only have a crucial role in patient care but also a leadership role for social justice on behalf of the most disadvantaged. Contrary to the common perception that virtue is largely individualistic, I argue that the virtue-based approach, built upon the Aristotelian structure and informed by Luke's theological view of healing, strongly supports models of health care that take seriously the social determinants of illness and health, and advocates action on behalf of the poor and the marginalized.

Second, I am a person of Vietnamese origin, and Confucianism has been a significant part of my cultural heritage. In today's Vietnam, the force of globalization is working to promote the four principles approach (usually termed "principlism"), understood to be *the* Western biomedical model, as the norm for Vietnamese medical practice, while the Confucian values and virtues are being questioned. My work on Lãn Ông's medical ethics, the first to apply the historical method to Lãn Ông's texts, is a response to this tendency. Though I discuss both Aristotle's virtue ethics and Lãn Ông's virtue-based medical ethics, I use the Aristotelian structure as the framework for integrating the insights from Luke's healing narratives, and I use Lãn Ông's work for correlation. As will become clearer as the chapters unfold, the virtue-based approach does

not try to resolve the differences between cultures and traditions, but highlights the distinctiveness of each, and calls for dialogue amidst diversity.

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INTRODUCTION: VIRTUE IN MEDICINE

The twentieth century renaissance of virtue ethics has also led to renewed interest in character and virtue in medical practice.[1] As Earl Shelp points out, this renaissance was heralded by the works of earlier scholars: George F. Thomas, Elizabeth Anscombe, G. H. von Wright and others who insisted that virtue ought to have its rightful place in modern ethical discourse. In response, moral philosophers Philippa Foot, James Wallace and Alasdair MacIntyre look to retrieve from ancient and medieval sources philosophical foundations for a virtue-ethics that is appropriate for modern contexts,[2] while Christian thinkers Peter T. Geach, David Harned, Stanley Hauerwas and others seek to link the Christian vision with praxis by proposing their own accounts of virtue. In the field of medicine, Philippa Foot was the first to apply a virtue ethics approach to the discussion of euthanasia.[3] A decade later, Rosalind Hursthouse brought an Aristotelian virtue-based perspective to the modern debate on abortion.[4] The following year, James F. Drane proposed a virtue-based medical ethics specifically centered on the role of physicians and the medical art.[5] Subsequently, Edmund Pellegrino and David Thomasma, largely in response to Robert Veatch's concern about the dangers of 'pure virtue', suggested a combined approach that incorporates both principles and virtues, drawing upon the

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[1] Cf. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice*, (New York : Oxford University Press, 1993).

[2] Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing: Dordrecht/ Boston/ Lancaster, 1985), vii.

[3] Philippa Foot, 'Euthanasia' in *Philosophy and Public Affairs*, 6, (1977), 85–112.

[4] Rosalind Hursthouse, *Beginning Lives,* (Oxford: Blackwell, 1987).

[5] James F. Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, (Kansas City, MO: Sheed & Ward, 1988).

Aristotelian-Thomistic tradition and applying it to modern medical context.[6]

Historically however, virtue and character are not foreign concepts in Western medical ethics. Going as far back as the Hippocratic writings, virtue was considered an indispensable part of the healing art. As Ferngren and Amundsen point out, because Greek thinkers of this period considered health an indicator of virtue, sometimes even the greatest of virtues, the physician ought to be in good health and of suitable weight.[7] To the ancient Greeks, the physician ought to be competent in the practice of healing, and an exemplar of dietetic discipline and healthy living. In the third century BCE, a transition occurred. The philosophical sects Stoicism, Epicureanism, and Cynicism promoted the view that happiness, the goal of human pursuit, could be achieved even at the expense of physical health. The values that they promoted, including self-sufficiency, independence of external controls, and self-mastery, led eventually to an ascetism that prized the health of the soul over physical well-being.[8] In addition to this ascetic tendency, there was also an important shift of emphasis from heroic to gentler qualities that came to shape Greco-Roman thought in the first two centuries of the Christian era: cosmopolitanism, humanitarianism and benevolence to all social classes within the Empire. The belief in the common kinship and equality of all persons, and the emphases on kindness, charity and forgiveness found in this period among Stoic and some Cynic writers came to influence medicine. Medical practice came to be viewed, at least by some, as a

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[6] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, (New York : Oxford University Press, 1993), 19.

[7] Gary B. Ferngren & Darrel W. Amundsen, 'Virtue and Health/Medicine in Pre-Christian Antiquity' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 12-16.

[8] Ibid., 17.

"philanthropic art." According to Galen, the ideal philosopher-physician is one motivated by *philanthropia*, and therefore is willing to treat the poor, and committed to the advancement of medicine.[9] For Galen, philanthropy is a desirable but not essential quality. Subsequently, compassion and philanthropy were highly promoted among the ideals of the healing profession. First century Roman physician Scribonius Largus insisted that the physician ought to assist the sick in every way possible without regard for their circumstances or moral character. Scribonius maintained that the practitioner of the medical art ought to possess not only competence, but sympathy (*misericordia*) and humaneness (*humanitas*).[10] Second century Stoic philosopher Serapion similarly stressed compassion, sympathy and brotherhood as important qualities of the physician. Ferngren and Amundsen see the shift of emphases in this period as a transition of ideals between classical and Christian medical ethics.

Right from its conception, Christianity has perceived the duty to care for the poor and the sick as an indispensable part of its mission.[11] Among the church offices, the diaconate has been specifically linked with this duty. During the times of epidemics, the Christian zeal to care for the suffering was most evident. By the early Middle Ages, monasteries had became places of refuge for the destitute, and religious men and women were deeply involved in the provision of medical care for the sick in hospitals. Medical charity was widely considered an integral part of the monastic movement that was

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[9] Ibid.

[10] L. Edelstein, in O. Temkin & C. L. Temkin (eds), *Ancient Medicine: Selected Papers of Ludwig Edelstein*, (Baltimore: The John Hopkins Press, 1967), 337-343, quoted in *ibid*., 20.

[11] Darrel W. Amundsen & Gary B. Ferngren, 'Virtue and Medicine from Early Christianity through the Sixteenth Century' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 49-59.

blossoming in this period. This zeal to serve the poor sick was essentially taken over by the mendicant orders beginning in the thirteenth century.

In the words of Henry Sigerist, Christianity played a vital role in determining the way in which the sick is cared for,

> Christianity came into the world as the religion of healing, as the joyful Gospel of the Redeemer and of Redemption. It addressed itself to the disinherited, to the sick and afflicted, and promised them healing, a restoration both spiritual and physical… It became the duty of the Christian to attend to the sick and poor of the community… the social position of the sick man thus became fundamentally different from what it had been before. He assumed a preferential position which has been his ever since.[12]

The commitment to service of the destitute has remained an essential feature throughout the history of Christianity. Early Christian authors looked to Christ as the true physician (*verus medicus*) who embodies perfectly the virtues essential in medical practice. The medical virtues, as modeled on Christ, include compassion, selflessness and philanthropy.[13] Furthermore, some Christian authors also adopted a highly idealized Hippocrates as an exemplar of medical virtue.[14]

Some treatises on medical ethics prior to the tenth century encouraged physicians to serve the poor as well as the rich, because works of charity would earn spiritual benefit for the giver. These authors maintained that physicians are to be compassionate and empathetic to patients in their suffering.[15] Interestingly, in fourteenth to sixteenth century Catholicism, the Church's concern with the practice of the confessional led to

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[12] Sigerist, H. E. *Civilization and Disease,* (Ithaca: Cornell University Press, 1943), 69-70. Quoted in *ibid*., 50.

[13] Amundsen and Ferngren, 'Virtue and Health/Medicine in Pre-Christian Antiquity,' 51.

[14] Pease, A. S. 'Medical Allusions in the Works of St Jerome' in *Havard Studies in Classical Philosophy* 25, 1914, 73-86.

[15]MacKinney, L. C. 'Medical Ethics and Etiquette in the Early Middle Ages: The Persistence of Hippocratic Ideals' in *Bulletin of the History of Medicine*, 26, 1952, 1-31.

articulations of medical values and virtues using the language of sin. The physician's competence in the medical art is upheld by the assertion that medical practice without sufficient knowledge and skills is a sin. It is a sin to prolong a patient's illness for one's monetary gains, or to demand excessive fees, especially from the poor. It is also a sin to abandon one's patient, even when there is no hope of recovery. Furthermore, physicians are required to provide free treatment to the poor where circumstances permit, and patient's death might result without their intervention.[16]

Eighteenth century Scottish physician and Professor of Physick at the University of Edinburgh John Gregory, in *Lectures on the Duties and Qualifications of a Physician* (1772), referred to sympathy as the foundational quality of a physician. He describes 'sympathy' as

> That sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites in us the most powerful manner to relieve them. Sympathy produces an anxious attention to a thousand little circumstances that may tend to relieve the patient.[17]

As Laurence McCullough points out, Gregory's account of the virtues in medical care is grounded in concern for the patient's interests.[18] Through the practice of sympathy, the physician comes to discern the patient's best interests in light of the goods of medicine. In order to act well and consistently in the service of patient interests, Gregory believed the physician ought to curb self-interest and cultivate certain virtues. Gregory asserted that the physician ought to protect the patient from harm. He highlighted the virtues of

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[16] Amundsen and Ferngren, 'Virtue and Medicine from Early Christianity through the Sixteenth Century,' 54.

[17] John Gregory, *Lectures on the Duties and Qualifications of a Physician,* (London: Strahan, 1772), 22.

[18] Laurence McCullough, 'Virtues, Etiquette, and Anglo-American Medical Ethics in the Eighteenth and Nineteenth Centuries' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 83.

attentiveness and candor, confidentiality and truthfulness, prudence and humanity.[19]

Thomas Percival's *Medical Ethics* (1803) also shows explicit references to the physician's virtues. However, in comparison with John Gregory, Percival was less concerned with patient interests and more with harmonious relation among the medical professions. Percival named a number of specific virtues in this influential paragraph,

> Hospital physicians and surgeons should minister to the sick, with due impressions of the importance of their office, reflecting that the ease, the health and the lives of those committed to their charge depend on their skill, attention, and fidelity. They should study, also, in their deportment, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.[20]

This paragraph later appeared almost verbatim in the American Medical Association's first *Code of Ethics* (1847, Ch1, Art I, #1). The earliest AMA *Codes*, which owes much in content to Percival's *Medical Ethics*, is itself an interesting mix of rules, virtues and rights.

Twentieth Century Developments in Virtue-Based Medical Ethics

In the aftermath of the Second World War, the Nuremberg trials ushered in a new era of medical ethics. The verdict against the Nazi physicians for their horrendous atrocities against human subjects resulted in the Nuremberg Code (1947), which has shaped biomedical ethics ever since. The Helsinki code and the Belmont Report subsequently reiterated the requirements on physicians and researchers in the treatment of human subjects and patients. While the Hippocratic tradition urges the physician to use their skills and knowledge "in order to benefit patients, and avoid harming them," the

[19] Ibid., 83-84.

[20] Thomas Percival, *Medical Ethics*, (Manchester: Russell, 1803), 71.

Nuremberg Code places its emphasis on patient's informed consent, which aims to safeguard human subjects against abuses at the hand of the health profession. The state of vulnerability created by the power imbalance between the clinician and the patient became the prime concern. The Nuremberg move is to restrict physician's power – and the power of the state – in order to protect the interests of patients and research subjects. In North American context, the patient rights movement which began in the late 1960s has also shaped biomedical ethics in favor of patient interests. These events and movements have led to sweeping changes in both methodology and priority in health ethics. In the three decades following the Nuremberg trials, despite ongoing resistance from members of the medical profession, the protection of vulnerable research subjects and of patients eventually emerged as the new priority for biomedical ethics. In the U.S., the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created in 1974 to advise on public policy and to develop ethical guidelines in relation to research subjects, especially those with certain disabilities.[21] As the new impetus brought about structural changes to ensure protection of patients and research subjects, it also seriously challenged the traditional health ethics that referred only to the virtues, duties and rights of physicians.[22] It is important to note that, a century before Nuremberg, it was believed that patient interests could be served best by the cultivation of the right virtues among physicians. For instance, John Gregory's concern for patient interests led him to propose higher moral standards among

[21] Albert Jonsen, 'The Ethics of Research with Human Subjects: Introduction' in Albert Jonsen, Robert M. Veatch, and LeRoy Walters (eds), *Source Book in Bioethics* (Washington, D.C.: Georgetown University Press, 1998), 8-9.

[22] One instance of this is the aforementioned First American Medical Association *Code of Medical Ethics* (Chicago: American Medical Association Press, 1847).

health practitioners. With the Nuremberg trials, a paradigm shift was set in motion, and sole reliance on the moral character of physicians was no longer considered adequate. The emerging discipline of bioethics, which has promoted patient rights from its beginning, represents an *alternative* approach to health ethics, rather than a revision of the traditional approach.[23] The subject matter of ethical discourse has moved from the health profession and the virtues to medical quandaries and how moral decisions can be discerned. Bioethicists, now including non-physicians who are trained in moral reasoning, utilize moral philosophical models – most often deontology and consequentialism – to provide answers to specific questions arising in health care. Thanks to the influential works of Tom Beauchamp and James Childress,[24] the principle-based approach has virtually become the norm in Euro-American bioethics. Moral directives found in professional codes of ethics, policy statements of health care institutions, and government directives have been largely expressed in terms of rules, principles, and rights. These radical changes have resulted in a near total eclipse of the concept of virtue in health care.

In parallel with this neglect, something else has also occurred in the last decades: the erosion of the concept of the medical profession as a moral community. This erosion poses a significant challenge to any discussion of virtue in medicine, because virtues are intelligible only within the context of a community. If Alasdair MacIntyre is right, then

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[23] See for instance Howard Brody, 'The Physician-Patient Relationship' in Robert Veatch (ed) *Medical Ethics* (Sudbury, Mass.: Jones and Bartlett Publishers, 1997); Albert R. Jonsen, *The Birth of Bioethics* (Oxford/New York: Oxford University Press, 1998).

[24] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* 5th ed, (New York: Oxford University Press, 1994).

the community and its practices are crucial in the cultivation and transmission of virtues, which themselves are understood in terms of the shared vision and goals of the community.[25] The view that health practitioners belong to a community that is bound together by a vision and an ethos is central to any discussion of virtues and moral character in health care. For medical practitioners, this is closely linked with the concept of professionalism, that is, to act in accordance with the moral standards of one's profession. Yet, the understanding of the health profession as a moral community has been progressively marginalized since Nuremberg. If the Nuremberg move is to empower medical laypersons so as to protect them from abuses at the hand of the medical profession, it has also left a lasting impact upon the profession. The concept of the medical profession as a conscientious self-regulating moral community was seriously questioned. In his influential 1981 book, Robert Veatch even challenged the very notion of "professional physician ethics" and argued for another model which aims to make physicians more accountable to the public.[26] In agreement with this view, physician and bioethicist Howard Brody looks upon the "old" medical ethics as a "privileged, in-house matter" which is determined only by physicians, and explains that it ought to be replaced by the 'new' biomedical ethics which is more open to public scrutiny.[27] The two authors' concern with accountability to the public – which is in line with the Nuremberg trajectory – is certainly valid. Yet, their views seem to question the very legitimacy of the concept of a profession, a community which is constituted by shared practices and values. In

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[25] Alasdair MacIntyre, *After Virtue* (Notre Dame/Indiana: Notre Dame University Press, 1981).

[26] Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981), 70-107.

[27] Howard Brody, 'The Physician-Patient Relationship' in Robert Veatch (ed) *Medical Ethics* (Sudbury, Mass.: Jones and Bartlett Publishers, 1997), 75-101.

recent years, other factors such as managed care have further contributed to the erosion, even denigration, of the concept of professionalism in medicine.[28]

Writing against this trend, Smith and Newton maintain that any good physician-patient relationship must include some account of the moral character of the doctor.[29] There are moral excellences or virtues that are widely valued within a fiduciary physician-patient relationship. James F. Drane in his influential work *Becoming a Good Doctor*, strongly argues for the revival of concepts of virtue and character in medical ethics precisely because medicine is different from other professions. Historically, medicine has been one among the professions in which members are devoted to a certain type of service to others, while committing themselves to high moral standards.[30] Building upon Aristotle's structure, Drane proposes a virtue-based theory in which medical virtues are personal and professional excellences that allow doctors to perform their function well on a consistent basis. Drane describes the needs of patients by identifying six dimensions of the physician-patient relationship: medical, spiritual, volitional (decision making), affective, social, and religious. Corresponding to these are six virtues that would enable the doctor to respond well to patient needs: benevolence, truthfulness, respect, friendliness, justice, and religion.[31] In a later work, Drane

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[28] Parsi, Kayhan, and Myles N. Sheehan (eds), *Healing as Vocation : A Medical Professionalism Primer* (Lanham, Md.: Rowman & Littlefield Publishers, 2006), vii-xiv.

[29] Smith, D. G. & Newton, L., 'Physician and Patient: Respect for Mutuality' in *Theoretical Medicine*, Feb, 1984, Vol.5(1), 43-60.

[30] James Drane, *Becoming a Good Doctor*: *The Place of Virtue and Character in Medical Ethics* (Kansas City, MO: Sheed & Ward, 1988), 14-15.

[31] Ibid., 23-24.

identifies friendship as the key virtue in medicine.[32] Despite his vigorous promotion of the virtues, Drane's agenda is not to replace principle-based bioethics with a virtue ethic, but to harmonize both elements in a coherent structure. Responding to Robert Veatch's critique,[33] Drane proposes a *middle position* that aims to avoid the problems of both pure virtue and pure rules.

Along similar lines, Edmund Pellegrino and David Thomasma propose "a combined approach" in their important work *The Virtues in Medical Practice*, also in response to Veatch's critique. Though they believe that a virtue-based approach does not by itself provide a sufficient foundation for medical ethics, they argue that virtue ethics is indispensable, because the character of the physician, and of the patient, is always at the heart of medical choice and action.[34] In their view, virtue-based ethics could – and ought to – be joined to principle-based ethics so that the limitations of each approach could be overcome.[35] Appealing to the works of Aquinas, the authors argue that not only can virtues and principles coexist, but they can also complement each other. In their effort to promote the virtues in medicine, Pellegrino and Thomasma provide a vigorous defense of the concept of the medical profession as a moral community. Within this community, members are bound together by a common practice, the medical art. Against modern attempts to *redefine* the medical profession, or to *replace* the fiduciary relationship with a

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[32] James F. Drane, 'Character and the Moral Life: A Virtue Approach to Biomedical Ethics' in Edwin R. Dubose, Ronald P. Hamel & Laurence J. O'Connell (eds), *A Matter of Principles?: Ferment in U.S. Bioethics*, (Valley Forge, Pa.: Trinity Press International, 1994), 284-309.

[33] See Robert M. Veatch, 'Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 329-345.

[34] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, (New York : Oxford University Press, 1993), 19.

[35] Ibid., 19-20.

contractual model,[36] the authors maintain that medical consultations cannot be reduced to business transactions in which services are exchanged for set fees. They list five features integral to medicine that make it distinctive: (1) the vulnerability and inequality of the medical relationship, (2) the fiduciary nature of the relationship, (3) the moral nature of medical decisions (4) the nature of medical knowledge, and (5) the ineradicable moral complicity of the physician in whatever happens to the patient.[37] In view of Veatch's critique, the authors boldly defend the concept of "professional ethics." Allen Buchanan defines a profession in terms of five elements: (1) special knowledge of a practical sort; (2) a commitment to preserve and enhance that knowledge; (3) a commitment to excellence in the practice of the profession; (4) an intrinsic and dominant commitment to serving others on whose behalf the special knowledge is applied; and (5) effective self-regulation by the professional group.[38] Because this commitment to service of others is intrinsic to the very concept of a profession, Pellegrino and Thomasma maintain that self-interest, which may be legitimate at the center of a business exchange, "must to a degree be suppressed in the interest of sick-persons," because of the nature of medical activity.[39] The authors defend the view that the medical profession is a moral community which is defined by a practice, and bound together by shared commitments. They define the goals of medicine as "the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the

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[36] As Robert Veatch proposes in *A Theory of Medical Ethics* (New York: Basic Books, 1981).

[37] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 42-44.

[38] Allen E. Buchanan, 'Is There a Medical Profession in the House?' in R.G. Spece, D.S. Shimm, and E.E. Buchanan (eds), *Conflict of Interest in Clinical Practice and Research*, (Oxford University Press: New York, 1996), 107.

[39] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 44.

patient to live with residual pain, discomfort, or disability."[40] In light of these, Pellegrino and Thomasma list promise keeping, protection of patient confidentiality, truth telling among the requirements of the physician-patient relationship. Furthermore, they propose eight virtues that are important in medicine: fidelity to trust, compassion, phronesis, justice, fortitude, temperance, integrity, and self-effacement.[41] In their subsequent work, the authors also discuss the Christian virtues faith, hope and charity in relation to medical practice.[42]

In this dissertation, I both build upon and suggest some revisions to the virtue theories proposed by Drane, Pellegrino and Thomasma. Drawing upon the works of Justin Oakley and Dean Cocking,[43] I maintain that an Aristotelian teleological framework provides a very adequate basis for virtue-based medical ethics, while the works of Aquinas, a further development of the Aristotelian framework, help resolve the apparent tension between virtue and principle. Furthermore, in response to Pellegrino's and Thomasma's view of the medical community, I argue for a synthesis of two conceptions of *community*: the exclusive and the inclusive views. While Pellegrino and Thomasma propose an exclusive view of community which consists only of physicians, Lisa Cahill argues for a more inclusive view of community which consists of all persons involved in patient care, especially in the context of the fight against the AIDS pandemic. Cahill

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[40] Ibid., 52.

[41] Ibid., 52-53.

[42] Edmund D. Pellegrino & David C. Thomasma, *The Christian Virtues in Medical Practice,* (Washington, D.C.: Georgetown University Press, 1996).

[43] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001). Also Justin Oakley, "Varieties of Virtue Ethics" in *Ratio* Volume 9, Issue 2, pages 128–152, September 1996. "A Virtue Ethics Approach," in Helga Kuhse, Peter Singer (eds) *A Companion to Bioethics*, (Oxford, UK; Malden, Mass., USA: Blackwell Publishers, 1998).

rightly points out that the global AIDS crisis has exposed the inadequacies of approaches to health ethics that ignore the social determinants of health and illness, such as poverty and gender inequality.[44] Cahill proposes a participatory model of bioethics that highlights the significance of teamwork, community projects and social action on behalf of the poor and disadvantaged. This involves broader conceptions of community, beyond the bounds of the physician-patient relationship. I advocate a synthesis of these two views, because each one has its own validity. With this synthesis, physicians have a distinctive specialized role within the health care community which is defined by its shared commitment to the health of patients. The broader community and its practices also provide a new context and texture to the medical virtues, and give rise to new virtues. For instance, physicians who are prompted by the virtue of justice would engage in projects that address the root causes of HIV/AIDS in cooperation with others who share this common goal. The community-based model of care adopted by Vietnam's Catholic AIDS care network is a good illustration of the participation of medical and non-medical persons in a common project.

Another significant question for any virtue theory of medical ethics is how *justice* is construed within its proposed framework. In the context of health care, the virtue of justice ought to be what prompts the moral agent to confront unjust structures that predispose persons to poverty and ill health. In this regard, I believe James F. Keenan's nature-based account provides a helpful theoretical framework for the virtues in health care, because it reflects the plurality of moral claims associated with a multitude of

[44] See further discussion on pages 28-29. Lisa Sowle Cahill, *Bioethics and the Common Good*, (Milwaukee: Marquette University Press, 2004); *Theological Bioethics: Participation, Justice, and Change,* (Washington, D.C.: Georgetown University Press, 2005).

communities to which each of us belongs.[45]

Jesus' Healings in Luke and the Healing Art in *Hải Thượng Y Tông Tâm Lĩnh*

Into the twenty first century, care for the poor and the sick has remained central to the mission of the Church. Yet, continued effort is required to articulate a health ethic that closely reflects the gospel message, especially in connection with Jesus' healings. In recent decades, a number of Christian authors have played significant roles in keeping Christian theology and the Gospel vision connected with the evolving discipline of biomedical ethics.[46] James Keenan has discussed the virtue of mercy in the context of health care, especially in regard to HIV/AIDS.[47] The Gospel of Luke presents a particular view of Jesus' healings that can inform a virtue-based Christian medical ethics. Three decades ago, the works of Alasdair MacIntyre and of Stanley Hauerwas

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[45] James F. Keenan, 'What Does Virtue Ethics Bring to Genetics' in Lisa Sowle Cahill (ed), *Genetics, Theology, And Ethics : An Interdisciplinary Conversation*, (New York: Crossroad Publications, 2005), 97-110. The virtues proposed by Pellegrino and Thomasma actually reflect a diverse range of moral claims associated with different types of relationship. For instance, the authors see *fidelity* to trust, and *compassion* as virtues associated with the physician-patient relationship, while the virtue of *justice* is discussed in the broader context of the whole society and beyond (national and international communities). Their theory does not address the complexity of these moral claims. For this reason, Keenan's theory of the virtues has a corrective role.

[46] Allen Verhey & Stephen E. Lammers (eds), *Theogical Voices in Medical Ethics,* (Grand Rapids: Eerdmans, 1993).

Allen Verhey (ed), *Religion and Medical Ethics: Looking Back, Looking Forward,* (Grand Rapids: Eerdmans, 1996).

Paul F. Camenisch, *Religious Methods and Resources in Bioethics,* (Dordrecht/ Boson/ London: Kluwer Academic Publishers, 1994).

James B. Tubbs Jr, *Christian Theology and Medical Ethics: Four Contemporary Approaches,* (Dordrecht/ Boson/ London: Kluwer Academic Publishers, 1996).

[47] James F. Keenan, *The Works of Mercy: The Heart of Catholicism*, 2nd ed (Lanham/Boulder: Rowman & Littlefield: 2008).

highlighted the crucial link between narrative, community, and the virtues.[48] Hauerwas rightly emphasized that Christian ethics ought to maintain a strong connection with its core narrative: the gospel of Christ.[49] It is this foundational narrative that provides the basic orientation and texture to the virtues. Within this frame, Luke's depiction of Jesus' healings provides a rich theological context for a Christian view of health care and the virtues specific to it. In Luke's view, Jesus' healings signal the dawning of a new era in which God's Reign became manifestly present in our world (Lk 10:20). Within this messianic age, Luke presents physical cure as part of the renewal of the whole person that occurs through the power of God at work in Jesus.[50] Healing is an integral part of God's gift of salvation that includes: (1) physical and spiritual well being; (2) the restoration of relationships with God, with self, and with others in community; and (3) freedom from dehumanizing constraints and controls.[51] Luke particularly stresses the social dimension of health and illness. More specifically, in the context of God's partiality toward the poor, Jesus' healing of deprived and downtrodden persons means the restoration of persons, who have been alienated by diseases and other forms of ritual uncleanness, to

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[48] Alasdair MacIntyre, *After Virtue* (Notre Dame, Ind.: University of Notre Dame Press, 1981/2007).

Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic* (Notre Dame, Ind.: University of Notre Dame Press, 1981); *Character and the Christian Life: A Study in Theological Ethics* (Notre Dame, Ind.: University of Notre Dame Press, 1975/1985); *The Peaceable Kingdom : a Primer in Christian Ethics.* (Notre Dame, Ind. : University of Notre Dame Press, 1983); *Vision and Virtue: Essays in Christian Ethical Reflection,* (Notre Dame, Ind. : University of Notre Dame Press, 1981).

[49] Allen Verhey also calls for a more vigorous engagement with Scriptures in the discernment of biomedical issues. Allen Verhey, *Reading the Bible in the Strange World of Medicine*, (Grand Rapids, Mich.: W.B. Eerdmans Pub. Co, 2003).

[50] Gaiser, Frederick J., *Healing in the Bible : Theological Insight for Christian Ministry (*Grand Rapids, Mich.: Baker Academic, 2010), 178-190.

[51] Brendan Byrne, *The Hospitality of God: A Reading of Luke's Gospel* (Strathfield NSW:St Paul, 2000), 195.

their rightful place among the Renewed People of God. Brendan Byrne sees in Jesus' healings concrete examples of the hospitality of God offered to the poor and the dispossessed.[52] In addition, God's restoration of downtrodden persons to full participation in the life of the community may require the conversion of the whole community; a conversion that makes the inclusion of such marginalized persons possible. In addition to this communal dimension, Jesus' gift of healing also extends beyond ethnic and social boundaries, to bring life not only to Israelites, but also to the Samaritan (Lk 17:12-19), the Gerasene man (Lk 8:26-39), and member of a Roman's household (Lk 7:1-10). As Gaiser also points out, Jesus' healing of individuals also serves as "a sign and an invitation of the healing of the community and the world".[53] In line with this, Jesus' love command which is illustrated by the parable of the Good Samaritan (Lk 10:30-37) provides an overarching context for a Christian understanding of health care.

In his recent doctoral dissertation, Yiu Sing Luke Chan argues that an integrated Scripture-based ethics requires an equal emphasis on both biblical scholarship and ethical hermeneutics.[54] This dissertation employs the critical historical method in the study of a number of Lukan texts on healing, then integrates the insights obtained from biblical scholarship into the Aristotelian structure of virtue ethics. Drawing upon the works of Joseph Kotva, Richard Burridge, and William Spohn, this project demonstrates that the healing narratives in Luke-Acts are congruent with the structure of virtue ethics, and with

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[52] Ibid., 196.

[53] Frederick Gaiser, *Healing in the Bible, Theological Insight for Christian Ministry*, 247.

[54] For a detailed discussion on the historical method and ethical hermeneutics, see Yiu Sing Luke Chan's doctoral dissertation, *Why Scripture Scholars and Theological Ethicists Need One Another: Exegeting and Interpreting the Beatitudes as a Scripted Script for Ethical Living,* Boston College, Theology Department, December 2010, 1-44.

the *imitation of Christ* motif.[55] Not only does Luke present an exemplary pattern in Jesus' healings, he also provides accounts of Jesus' disciples performing healing acts in conformity with the examples set by Jesus the healer (Acts 3:1-10). In addition, Jesus' commission of the Twelve, and subsequently of the Seventy, signifies the call of Christian disciples to continue Christ's ongoing salvific work in the Holy Spirit.[56] Luke's healing narratives call for a more holistic view of health care, because healing in its proper sense requires not only physical cure, but also the restoration of relationships: with self, with God and with others. Furthermore, Luke's emphasis on the *social dimension* of health and illness also lends support to approaches to health care that take seriously the social determinants of health, such as poverty, exploitation of the poor and the disadvantaged, discrimination and exclusion of persons based on gender, sexual orientation, class, race, culture, and religion.[57]

A Vietnamese Confucian Physician on the Healing Art

The works of Hải Thượng Lãn Ông, who is generally considered the founder of Vietnamese medical ethics, offer valuable insights into the cultural context within which

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[55] Joseph J. Kotva, *The Christian Case for Virtue Ethics*, (Washington D.C.: Georgetown University Press, 1996). Richard Burridge, *What are the Gospels? A Comparison with Graeco-Roman Biography* (Cambridge: Cambridge University Press, 1992); *Imitating Jesus: An Inclusive Approach to New Testament Ethics* (Grand Rapids, MI: Eerdmans, 2007). William C. Spohn, *Go and Do Likewise: Jesus and Ethics*, (New York/London: Continuum, 2003); "Jesus and Moral Theology" in James Keating (ed), *Moral Theology: New Directions in Fundamental Issues*, (Mahwah, NJ: Paulist, 2004), 28-45.

[56] Donald Senior & Carroll Stuhlmueller, *The Biblical Foundations for Mission* (Maryknoll, New York: Orbis Books, 1983).

[57] See James F. Keenan (ed), *Catholic Ethicists on HIV/AIDS Prevention* (New York/London: Continuum, 2005).

the gospel message is received. Hải Thượng Lãn Ông,[58] birth name Lê Hữu Trác (1724-1791), is the most prominent Vietnamese physician of the eighteenth century. To date, his monumental work, *Hải Thượng Y Tông Tâm Lĩnh* [The Theory and Practice of Hải Thượng School of Medicine], consisted of 28 books that detail the theory and practice of traditional Eastern medicine, has remained the most complete and influential work in this field by a Vietnamese author. This immensely important work begins with a series of moral precepts, *Y Huấn Cách Ngôn* [Moral Precepts for Physicians] which define both the nature of the healing art and moral obligations of the physician. Lãn Ông's *Moral Precepts for Physicians* both reiterates earlier moral guidelines in Chinese medical literature and develops them further in a distinctive direction. His frequent emphasis on the physician's competence and moral character represents a sustained attempt to uphold the fiduciary nature of the healing art. An exemplar of the virtuous healer, Lãn Ông shows an unfailing commitment to learning and to medicine. His view of the physician as the guardian of human lives, and his particular concern for the poor and disadvantaged highlight the social obligations of the physician. In line with the Chinese medical tradition, Lãn Ông insists that the healing art is the humane art (*ren shu*, *nhân thuật*), and its practitioners must show through their conduct moral qualities worthy of that name. Lãn Ông also records a number of case studies from his own practice, and presents them under two categories: cases that he treated successfully (*Dương Án*), and cases that resulted in death (*Âm Án*). These case studies provide a unique window into the moral character of this remarkable physician. Also using the historical critical method, this

[58] This penname, which literally means 'lazy man of Hải Thượng,' expresses his lack of political ambition. This self description is significant in a society that sought to appoint learned scholars to public office. The term 'Hải Thượng' combines the names of Hải Dương Province and Thượng Hồng District where he came from. Hải Thượng Lãn Ông, *Hải Thượng Y Tông Tâm Lĩnh,* (Hà Nội: Nhà Xuất Bản Y Học, 2008), 5.

dissertation provides a translation and commentary on the *Moral Precepts*, and on relevant excerpts from *Theory and Practice* in order to engage the distinctiveness of a cultural context in which the gospel message is received. Lãn Ông's strong emphases on humaneness, sincerity, self-sacrifice, and compassion for the poor can provide the foundations for a medical ethic that is directly relevant for twenty-first century health care in Vietnam.[59]

To date, a very limited amount of academic work has been done on Lãn Ông's medical ethics. Though his *Moral Precepts for Physicians* have often been cited by Vietnamese authors writing on traditional medicine, no historical study of his texts has been done. A number of Vietnamese authors, many of them physicians, have stressed the significant contributions of Lãn Ông to traditional Vietnamese healing art.[60] Lê Trần

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[59] In her three year research (2006-2009) into the ethical standards of physicians in public hospitals in Vietnam, Prof. Nguyễn Thị Minh Đức of The Medical School of Hanoi found widespread behavior patterns that would amount to violations of medical ethics: 40.5% physicians coerced patients into paying extra sums of money for treatment, 39.9% physicians prescribed expensive items for their own financial gain, others made patients come to their private clinics for treatment. Article by Kiều Oanh, electronic magazine, Vietnam Net, May 12, 2010. At www.vietnamnet.vn. Accessed June 15, 2010.

[60] During my recent research in Vietnam (August 2011), I was able to obtain a nineteenth century text of Lãn Ông's *Moral Precepts* in original Chinese script at the Han-Nom Institute, Hanoi. Hải Thượng Lãn Ông, 海上懶翁醫宗心領全帙 (*Hải Thượng Lãn Ông Y Tông Tâm Lĩnh Toàn Trật*) [The Complete Texts of Hải Thượng Lãn Ông School of Medicine], archive code A.902/1-10 of the Han-Nom Institute of Hanoi, 183 Đặng Tiến Đông, Đống Đa, Hanoi, Vietnam. The tome is wood printed in traditional Chinese, 6,000 pages, of 26 x15cm.

I also received helpful input from interviews with practitioners and scholars in traditional medicine in Vietnam, among whom is the director of The National Institute of Traditional Medicine of Vietnam and Tuệ Tĩnh Hospital (Hanoi), Prof. Trương Việt Bình, whose guidance was especially helpful for my research. Prof. Trương discusses Lãn Ông's medical ethic in a seminar paper, 'Một Số Vấn Đề Về Y Thuật, Y Đức và Y Đạo của Hải Thượng Lãn Ông,' The National Institute of Traditional Medicine, Hanoi, 2004. Dr Phan Quy Nam, the medical director of Nguyen Tri Phuong Hospital and lecturer at the Medical School of Ho Chi Minh City also provided me with helpful insights into the current health services in Vietnam, and how Lãn Ông's ethical guidelines can inform health practice in Vietnam today.

The recent national conference on biomedical ethics at The Medical School of Hanoi also discussed Lãn Ông's moral views and how they should apply to contemporary health care in Vietnam. Nguyễn Quốc Triệu & Nguyễn Đức Hinh (eds), *Đạo Đức Y Học* [Biomedical Ethics: Plenary Papers of the National Conference on Biomedical Ethics] (Hanoi: Nhà Xuất Bản Y Học, 2011).

Đức of The Institute of Eastern Medicine (Vietnam) published a book on Lãn Ông's work in 1966.[61] In 1970, at the 250th anniversary of Lãn Ông's birth, two issues of the Vietnamese-language *Journal of Eastern Medicine* were devoted to Lãn Ông and his works.[62] In their brief chapter in *Vietnamese Traditional Medicine* (1993), Dr. Hoang Bao Chau, Dr. Pho Duc Thuc and Huu Ngoc gave an introduction to Lãn Ông's medical texts and translated part of his *Moral Precepts* into English.[63] Professor and physician Nguyễn Văn Thang has published a number of books and articles on Lãn Ông's life and medical texts.[64]

In broad terms, Lãn Ông's *Moral Precepts for Physicians* both reiterates earlier moral guidelines in Chinese medical literature and develops them further in a distinctive direction. His frequent emphasis on the physician's competence and moral character represents a sustained attempt to uphold the fiduciary nature of the healing art. In addition, Lãn Ông's particular concern for the poor – especially the widows, the orphans, the lone elderly – highlights the social responsibility of physicians, whom he defines as "guardians of human lives." Lãn Ông's moral thought shows significant influence from Confucianism. For this reason, his medical ethics texts are read against the major texts of traditional Chinese medical ethics, including the works of Sun Ssu-miao (581-673 CE),

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[61] Lê Trần Đức, Viện Nghiên Cứu Đông y. *Thân Thế và Sự Nghiệp Y Học của Hải Thượng Lãn Ông*. Hà Nội: Nhà Xuất Bản Y Học/ Thể Dục Thể Thao, 1966.

Nguyễn Trung Khiêm 'Thân Thế và Sự Nghiệp cụ Hải Thượng Lãn Ông' *Tạp Chí Đông Y*, số 1, 2 năm 1958.

[62] *Tạp Chí Đông Y*, số 110-111 tháng 10-12 năm 1970. Đặc san kỷ niệm 250 năm ngày sinh Hải Thượng Lãn Ông.

[63] *Vietnamese Traditional Medicine* (Hanoi: The Gioi Publishers, 1993), 5-29.

[64] Nguyễn Văn Thang, *Hải Thượng Lãn Ông: Nhà Y Học Lớn, Nhà Văn Hóa Lớn*. Nhà Xuất Bản Văn Hóa Thông Tin Hà Nội, 1995, 2001. *Khái Yếu Tác Phẩm Lãn Ông Tâm Lĩnh*. Viện Y Học Cổ Truyền Việt Nam. Hà Nội: Đại Học Y Khoa Hà Nội, 1996. *Hải Thượng Lãn Ông và Tác Phẩm Lãn Ông Tâm Lĩnh*. Hà Nội: Nhà Xuất Bản Y Học, 1998.

and Chen Shih-kung (?1555 – 1636 CE). An overview of traditional Chinese medical ethics will be provided, building upon the scholarship of Paul Unschuld, [65] Tao Lee,[66] Ruiping Fan,[67] and Jing-Bao Nie.[68] The dissertation also elaborates on the major themes in Lãn Ông's texts by referring to major Confucian classics, especially the Four Books: *The Analects of Confucius*, *Mencius*, *Great Learning* and *Doctrine of the Mean*.[69] James T. Bretzke has also provided helpful studies of Confucian ethics. His bibliographical works provide a useful guide for research in this area.[70]

The recurrent themes that run across the ancient Greco-Roman culture, Jesus'

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[65] Paul U. Unschuld, *Medical Ethics in Imperial China* (Berkeley/Los Angeles: University of California Press, 1979). *What is Medicine?: Western and Eastern Approaches to Healing*, tr. by Karen Reimers (Berkeley, Los Angeles/London: University of California Press, 2009).

[66] Tao Lee, 'Medical Ethics in Ancient China' in Robert M. Veatch (ed), *Cross-Cultural Perspectives in Medical Ethics* (Boston, MA: Jones and Bartlett, 1989), p. 132-141.

[67] Ruiping Fan, 'Reconstructionist Confucianism and Health Care: An Asian Moral Account of Health Care Resource Allocation' in Journal of Medicine and Philosophy 2002, Vol. 27, No. 6, pp. 675–682.

'Which Care? Whose Responsibility? And Why Family? A Confucian Account of Long-Term Care for the Elderly' in *Journal of Medicine and Philosophy*, 32:495–517, 2007.

[68] Jing-Bao Nie, 'After Cheng (Sincerity): The Professional Ethics of Traditional Chinese Medicine' in Kayhan Parsi & Myles N. Sheehan (eds), *Healing as Vocation: A Medical Professionalism Primer* (Lanham/Boulder/New York/Toronto/Oxford: Rowman & Littlefield Publishers, 2006), 61-76.

[69] Among commentaries on the Confucian classics are Feng Yu-lan, *A History of Chinese Philosophy*, 2 Vols, tr. Derk Bodde, (Princeton: Princeton University Press, 1953).

Phan Bội Châu, *Khổng Học Đăng* (Saigon: Đại Nam, 1980) [The Radiance of Confucianism]

Trần Trọng Kim, *Nho Giáo* (Hà Nội: Nhà Xuất Bản Văn Hóa Thông Tin, 2001) [Confucianism]

Giản Chi & Nguyễn Hiến Lê, *Đại Cương Triết Học Trung Quốc*, (Saigon: Cảo Thơm, 1965) [A Companion to Chinese Philosophy]

Bi-lingual Viet-English: Institute of Han Nom Studies (Vietnam) &Harvard Yenching Institute (USA), Trinh Khac Manh & Phan Van Cac (eds), *Confucianism in Vietnam: International Conference Proceedings* (Hanoi: Social Sciences Publishing House, 2006).

[70] James T. Bretzke, *Bibliography on East Asian Religion and Philosophy,* (Lewiston, N.Y. : E. Mellen Press, 2001).

'The 'Tao' of Confucian Virtue Ethics' in *International Philosophical Quarterly* 35.n1 (March 1995): p. 25(17).

Sim, Luke J. & James T. Bretzke, "The Notion Of Sincerity (Cheng) In The Confucian Classics" *Journal of Chinese Philosophy*, 1994, Vol.21(2), p.179-212.

healings, and Lãn Ông's Confucian ethics are truly remarkable. This dissertation also provides a correlative study of Luke's view of Christian love and Lãn Ông's understanding of humaneness. Jesus' double love command, illustrated by the parable of the Good Samaritan, is especially helpful, for it represents a distinctive view of love-in-action that transcends all socio-cultural boundaries. This parable captures the love that Luke's Jesus embodies, and the virtues of mercy, compassion, and hospitality in Luke's healing narratives. It also resonates with the evolving theme of universality in Luke-Acts. A parallel study of Jesus' love command and Lãn Ông's view of humaneness provides important insights for the development of a medical ethics that acknowledges both the Vietnamese cultural heritage and the Christian vision. Furthermore, in the context of the AIDS epidemic in Vietnam, a correlative study of Jesus' partiality toward the poor in Luke and Lãn Ông's concerns for poor widows and orphans – also for female entertainers and prostitutes in his context – will be of particular relevance for contemporary Vietnam.

Theology in Cultural Context: Dialogue Vs Displacement

In this age of globalization, interactions between moral principles – often thought to be universally valid – and particular cultures around the globe have exposed the *cultural presumptions* behind such principles. In biomedical ethics, the cultural gap between East and West has remained a challenge. In the last two decades, attempts to bridge this gap by finding ways to apply the four principles to East Asian Confucian context have led to

numerous problems. As authors Ruiping Fan, Jing-Bao Nie, and others point out,[71] there are irreconcilable differences in attitude, value, and emphasis between a Confucian culture and Euro-American liberalism. In particular, the principle of respect for autonomy (or right of self-determination), which is highly valued in North American culture, does not resonate readily with a Confucian family-based health situation. But cultural discrepancies are not simply a matter of academic interest. As Xiaoyang Chen and Ruiping Fan indicate, the sheer pressure of globalization (which in East Asia often means Westernization) has resulted in the domination of *the* Western biomedical model in China, while the validity of the family-based harmony-oriented Confucian structures of decision making has been questioned.[72] More seriously, Ruiping Fan has warned that the uncritical implementation of the four-principles approach, with its individualistic biases, in East Asian Confucian context will lead to the fragmentation of families into isolated individuals.[73] In another article, he also shows concerns that the use of Western science as the standard has marginalized traditional medicine in China.[74] As it turns out, these

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[71] Fan, Ruiping. 'Self-Determination vs. Family-Determination: Two Incommensurable Principles of Autonomy' in *Bioethics* 1997, Vol. 11, No.3-4, pp. 309–322.

Fan, Ruiping & Benfu Li, 'Truth Telling in Medicine: The Confucian View' in *Journal of Medicine and Philosophy* (2004) 29 (2): 179-193.

Fan, Ruiping and Julia Tao, 'Consent to Medical Treatment: The Complex Interplay of Patients, Families, and Physicians' in *Journal of Medicine and Philosophy* 2004, Vol. 29, No. 2, pp. 139–148.

Angeles Tan Alora and Josephine Lumitao (2001) bring a very useful cross-cultural perspective that highlights the virtues in Filipino health ethics. See Angeles Tan Alora & Josephine M. Lumitao (eds), *Beyond a Western Bioethics: Voices from the Developing World,* (Washington D.C.: Georgetown University Press, 2001).

[72] Chen, Xiaoyang & Ruiping Fan, 'The Family and Harmonious Medical Decision Making: Cherishing an Appropriate Confucian Moral Balance' *J Med Philos* (2010) 35(5): 573-586.

[73] Fan, Ruiping. 'Reconstructionist Confucianism and Health Care: An Asian Moral Account of Health Care Resource Allocation' in *Journal of Medicine and Philosophy*. 2002, Vol. 27, No. 6, pp. 675–682 .

[74] Fan, Ruiping. 'Modern Western Science as a Standard for Traditional Chinese Medicine: A Critical Appraisal' in *The Journal of Law, Medicine & Ethics*, Volume 31, Issue 2, pages 213–221, June 2003.

"universal principles" are heavily laden with the presumptions of their original socio-political context. The uncritical adoption of these principles will lead to the replacement of East Asian values and structures by Western standards, and the alienation of people from their own cultural heritage in their home country.[75]

Filipino-American theologian Eleazar Fernandez has rightly identified the oppressive nature of making certain principles, which are themselves culturally-bound, normative for all human relations across cultures.[76] This cross-cultural dimension, which is increasingly relevant in a globalized world, is most often overlooked by defenders of principles and rules. In his critique of virtues in favor of principles, Robert Veatch reasons that because virtues are culturally relative, it is hard to propose a list of virtues in medicine that is universally valid.[77] According to Veatch, principles would be the better option in providing moral guidelines for action. In his major work, *A Theory of Medical Ethics*, Veatch draws upon the social contract tradition and Rawls' theory of justice to propose a triple contract as the philosophical foundation of biomedical principles. From his perspective, moral principles are formulated through a process of consensus, or social contract, which gives them validity.[78] This raises complex issues about the very basic

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[75] An example in Vietnamese context: in 2008, author Huỳnh Tấn Tài, of the University of Illinois Chicago, was part of the Joint Commission that proposed a working bioethical framework for Vietnam. This proposal draws exclusively on North American authors, and details practical ways to balance the principles of beneficence and non-maleficence against respect for autonomy. Article in Vietnamese, with bibliography, accessed on April 19, 2011 at: http://www.ykhoanet.com/binhluan/huynhtantai/080103_huynhtantai_YducVN.pdf.

[76] Eleazar S. Fernandez, *Reimagining the Human: Theological Anthropology in Response to Systematic Evil,* (St Louis, MO: Chalice Press, 2004).

[77] Robert Veatch, 'Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics' in Earl Shelp (ed), *Virtue and Medicine*, 329-345.

[78] See Robert M. Veatch, 'Professional Medical Ethics: The Grounding of Its Principles' in *Journal of Medicine and Philosophy* 4 (1979): 1-19. *A Theory of Medical Ethics* (New York: Basic Books, 1981).

premises of the contractual model, which we will not discuss.[79] The issue here is that, even if Veatch's theory can explain the formation and widespread use of certain biomedical principles (and not others) within the North American context, this contractual model breaks down at the global level. When Western principles interact with the values and norms of other cultural traditions, the pressures to modernize (which often means to Westernize) would operate to produce not a new consensus, but the forced displacement of indigenous values and norms by these dominant principles. This displacement often occurred through socio-economic pressures rather than a process of intellectual exchange on a level-field.[80] The problem with promoting the principle-based approach in the global context is that it frequently overlooks and suppresses cultural diversity. This is not to say that all values and moral norms are culture-relative, and *therefore* there is no validity in claims about universal human capabilities or human goods. But it is to say that too often the promotion of "universal" principles does result in uniformity, through the dangerous marginalization of values and norms of indigenous cultures, and the alienation of persons from their own cultural roots even in their own countries. This dissertation shows that the virtue-based approach is a better bridge across cultures, precisely because it explicitly acknowledges, rather than trying to resolve, cultural diversity. The chapters that follow demonstrate that the promotion of virtues,

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[79] Howard Brody summarizes the objections to the contract model in his chapter "The Physician-Patient Relationship" in Robert M. Veatch (ed) *Medical Ethics*, (Sudbury, Mass.: Jones and Bartlett Publishers, 1997), 75-102.

[80] Within North American context itself, it has been shown that the four principles approach does not apply readily to patients of Hispanic or East Asian backgrounds. See for example, Deborah L. Volker, "Control and End-of-Life Care: Does Ethnicity Matter?" *American Journal of Hospice and Palliative Care* November/December 2005 vol. 22 no. 6, 442-446.

which are culturally grounded, both strengthens cultural distinctiveness and facilitates cross-cultural dialogue.

In theological ethics, it is also important to guard oneself against presumptions about such "universal" norms. For centuries, local customs and values of mission countries have to find validity in reference to a standard set of practices which have been defined as Christian orthodoxy. Such standards of orthodoxy, themselves culturally bound, represent *one* particular set of cultural expressions – among other cultural expressions – of the Gospel of Jesus. Yet, when they are defined as orthodox Christian standards with universal validity, the result is the marginalization of local values and practices. The Chinese Rites controversy resulting in the 1715 Papal bull *Ex illa die,* which had significant repercussions in Vietnam, is a good illustration of the point at hand. For this reason, attention must also be paid to the distinctiveness of the cultural context within which the Gospel message is heard. This dissertation presents a virtue-based approach as the bridge between the Gospel vision and Christian medical practice, paying due attention to cultural distinctiveness. This is not to endorse uncritically all cultural customs and values, for that would amount to idolatry. But it is to maintain that culture *both* requires transformation by the Gospel *and* itself reflects something of the sacred. In light of this, the parallel study of Luke's gospel and the texts by Lãn Ông, an author of Vietnamese Confucian background, both helps contextualize the Gospel and affirms the validity of certain values and norms of this culture. Furthermore, in contemporary Vietnamese context, if the four principles of bioethics may be characterized as clinic-centered and autonomy-driven, the study of the biblical source and an eighteenth century Vietnamese author will help correct the excesses, particularly in favor of the poor and the

dispossessed.

Structure of the Dissertation

Chapter One discusses the theoretical grounding of the medical virtues in the works of some contemporary authors. A brief historical overview is followed by a review, in some detail, of the recent works on virtue-based medical ethics by Justin Oakley and Dean Cocking, James F. Drane, Edmund Pellegrino and David Thomasma. James F. Keenan's works which highlight the interplay between virtue ethics and anthropology provide a theoretical basis for the virtues in health care, while the works of Daniel Daly on Aquinas help resolve the apparent tension between virtue and principles.

Chapter Two begins with a discussion on methodology in regard to the Bible and Christian ethics, drawing upon the works of Joseph Kotva, Richard Burridge, and William Spohn. It is followed by a study of the healing narratives in Luke-Acts against their historical context. There are a number of virtues attributed to God and to Luke's Jesus that are apparent in the healing narratives: mercy, compassion, and hospitality. This chapter demonstrates that Luke's theological perspective and his accounts of Jesus' healings provide the narrative context for a virtue-based theological medical ethics.

Chapter Three examines a virtue-based medical ethic from a Vietnamese Confucianist context through the study of relevant texts from the corpus of Lãn Ông's works. Well grounded in the Chinese medical tradition, Lãn Ông understands medicine as the art of humaneness, and emphasizes the vital moral qualities in a physician: competence and honesty. Lãn Ông's particular emphasis on the welfare of the poor also

points to the social responsibility of health practitioners. This study provides a translation and commentary on *The Moral Precepts for Physicians*, and some selected texts from Lãn Ông's corpus, *Hải Thượng Y Tông Tâm Lĩnh*.

Chapter Four begins by recapturing Luke's theological vision, which I argue can provide the basis for a Christian view of health care. Then I discuss the cross-cultural dimension of the virtues through the correlative study of Jesus' love command in Luke 10:25-42 and Lãn Ông's view of humaneness. The correlative study will bring out the distinctive features of each tradition, as well as the common ground shared between them.

Chapter Five discusses Vietnam's Catholic AIDS care network which both provides a concrete example of Christian love through service, and demonstrates a range of practices conducive to the formation of character and virtues. This chapter engages the community-based response that embodies the Christian vision of health care within a more inclusive community: empowerment of community health workers, service and empowerment of the poor, community-building activities, and networking. This study serves as an illustration of the social dimension of health care, the healing community, and the virtues of mercy, compassion, and inclusiveness.

Chapter I: VIRTUE AND CHARACTER IN MEDICAL ETHICS

1.1. INTRODUCTION: VIRTUE AND THE MEDICAL PROFESSION IN NORTH AMERICAN CONTEXT

As we have discussed, the Nuremberg Trials ushered in a new era of biomedical ethics in which many traditional values and concepts are called into question. The medical profession, once trusted to serve the public good by adhering to self-imposed principles and standards of excellence, is now obliged to make itself more transparent to the public. The principle-based approach has gained increasing popularity in this new context,[1] while references to physician character and virtues become marginal, even treated with suspicion. Deontologist Robert Veatch even goes as far as arguing that emphasis on virtue can lead to erroneous acts, for it can lead to "a sense of hubris, a disinclination to submit to peer or public monitoring."[2] Veatch believes that virtue is *unnecessary* in "stranger medicine," the term which characterizes most clinical settings in North America. Being primarily concerned with moral acts, Veatch argues that virtue-based ethics should only have a limited, secondary role, namely to promote right acts in accordance with moral principles and rules.[3] In other words, Veatch takes a strict

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[1] John H. Evans provides a sociological analysis of the growth of principle-based bioethics in North America. See "A Sociological Account of the Growth of Principlism" in *The Hastings Center Report;* Sep/Oct 2000; 31-38.

[2] Robert M. Veatch, "Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics" in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing: Dordrecht/ Boston/ Lancaster, 1985), 329.

[3] On this point, Veatch's position is in line with William Frankena. See "The Ethics of Love Conceived as an Ethics of Virtue" in *Journal of Religious Ethics* Vol. 1 (1973), 21-31; "Conversations with Carney and Hauerwas" in *Journal of Religious Ethics* Vol. 3, No. 1 (1975), 45-62. Note that some exponents of Kantianism and consequentialism also acknowledge the connection between right action and an agent's

Kantian approach to virtue. Similar to Veatch, Robert Louden holds that virtue ethics alone is inadequate, and must be complemented by act-oriented ethics.[4]

Despite Veatch's skepticism, a body of research over the last two decades has shown that a certain physician style of interaction is associated with positive clinical outcomes including patient satisfaction, trust, adherence to treatment, symptom resolution and improved health status.[5] Among physician characteristics, good communication with patients is notably associated with better health results.[6] Training in communication skills to improve physician-patient interaction has been shown to have a significant impact upon outcomes.[7] Furthermore, despite the overwhelming success of principlism in bioethics, certain moral excellences or virtues continue to be highly valued within the medical profession, and those who aspire to work in the field have to demonstrate appropriate dispositions and skills.[8] Physician "interactional style" and good

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character. See Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001), 8.

[4] Robert Louden gives a similar critique of virtue ethics in "On Some Vices of Virtue Ethics" in Robert B. Kruschwitz and Robert C. Roberts (eds), *The Virtues: Contemporary Essays on Moral Character* (Belmont, CA: Wadsworth Publishing, 1987), 66-73.

[5] See S.H. Kaplan, S. Greenfield, B. Gandek, W.H. Rogers and J.E. Ware, "Characteristics of Physicians With Participatory Decision-Making Styles" in *Annals of Internal Medicine*, 124 5 (1996), 497–504.

K.D. Bertakis, D. Roter and S.M. Putnam, "The Relationship of Physician Medical Interview Style to Patient Satisfaction" in Journal *of Family Practice*, 32 2 (1991), 175–181.

S.A. Flocke, W.L. Miller and B.F. Crabtree, "Relationships Between Physician Practice Style, Patient Satisfaction, and Attributes of Primary Care" in *Journal of Family Practice*, 51 10 (2002), 835–840.

[6] See Franks, P., Jerant, A. F., Fiscella, K., Shields, C. G., Tancredi, D. J., & Epstein, R. M. "Studying Physician Effects on Patient Outcomes: Physician Interactional Style and Performance on Quality of Care Indicators" in *Social Science and Medicine, 62,* (2006), 422–432.

[7] Kelly B. Haskard, Summer L. Williams, M. Robin DiMatteo, Robert Rosenthal, Maysel Kemp White, and Michael G. Goldstein "Physician and Patient Communication Training in Primary Care: Effects on Participation and Satisfaction" in *Health Psychology*, (2008), Vol. 27, No. 5, 513–522.

[8] An example of this is the use of the Multiple Mini Interview (MMI) as an entry requirement for medical schools. The interviews examine candidates for people skills, such as the ability to work in a team, to communicate effectively with patients, and to establish patient trust. The MMI is being used in eight U.S.

communication refer to the personal excellences that enable physicians to perform their role well. In light of Aristotle's virtue theory, these personal excellences are the medical virtues that help physicians excel in their professional role, and can be cultivated through practice. If principle-based ethics is helpful in the prevention of physician misconduct, it can also promote minimalistic attitudes and conduct that could result in poor medicine. This is the reason why Aquinas in his *Summa Theologiae* places moral precepts in the teleological context, in which precepts are at the service of the cultivation of virtues.[9]

Another significant development over the last two decades has been the revival of the concept of *professionalism* in medicine. In their overview of the medical profession, Myles Sheehan and Kayhan Parsi identify a period in which the idea of medicine as a profession was weakened when the business model was applied to health care. This resulted in an atmosphere of "almost laissez-faire medical capitalism" in the United States.[10] With the weakening of the professional ideals, medical practice became profit-oriented and business-driven, which became even more apparent in the early 1990s after the universal health care plan proposed by the Clinton administration was defeated. Subsequently, however, there was an upsurge of interest in physicians, medical practice, and the nature of medicine as a profession, partly because of the frustration among both physicians and members of the public with the way medical services were delivered, and

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medical schools, including Virginia Tech Carilion, Stanford, University of California Los Angeles, and the University of Cincinati, as well as 13 medical schools in Canada. See Gardiner Harris, "New for Aspiring Doctors, The People Skills Test" in *The New York Times*, July 11, 2011, page A1.

Similarly, the clinical examination for specialist physicians in Australia aims explicitly to test "not only clinical ability but also attitudes and interpersonal skills." Nicholas J. Talley and Simon O'Connor, *Examination Medicine: A Guide to Physician Training*, 6th edition, (Elsevier: Chatswood, NSW, 2010), 14.

[9] Daniel Daly, "The Relationship Of Virtues And Norms In The Summa Theologiae," 214–229

[10] Myles N. Sheehan & Kayhan Parsi, *Healing as Vocation: A Medical Professionalism Primer,* (Lanham/ Boulder/ New York/ Toronto/ Oxford: Rowman & Littlefield, 2006), x.

partly because of a feeling that things could be improved.[11] Without romanticizing medicine in past ages, Sheehan and Parsi maintain that professionalism is an indispensible part of medicine because it is linked with the high moral standards expected of its members by society, along with the social privileges and trust which are part of the "informal contract" between society and the profession.[12] From a different angle, Matthew Wynia and his co-authors hold that the professions play a crucial role in the protection of vulnerable persons in society.[13] The professions are also custodians of certain social mores and values, such that a decline in professionalism would lead to a rise in societal problems.

A key development took place in 2001, when the Accreditation Council for Graduate Medical Education (ACGME) identified *professionalism* as one among the six core areas of competency to be used in the accreditation of the medical residency programs in the United States. The ACGME assesses "competency in professionalism" in terms of responsibility in carrying out professional duties; responsiveness and availability; self-sacrifice; the following of ethical principles in dealings with patients, their families and other health care workers; and sensitivity in the care of patients of different ethnic and economic backgrounds.[14] The formal endorsement of

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[11] Ibid, viii.

[12] Ibid, xi.

[13] M. K. Wynia, S. R. Latham, A. C. Kao et al, "Medical Professionalism in Society," in *New England Journal of Medicine* 341 (1999): 1612-16.

[14] The ACGME website under "Core Competencies" (2001), at http://www.acgme.org/acwebsite/RRC_280/280_corecomp.asp. Accessed February 17, 2012. For discussion on the adequacy of these criteria of professional competence and their application in the (re)structuring of residency programs, and medical training in general, see Robins L.S., Braddock C.H. 3rd, Fryer-Edwards K.A., "Using the American Board of Internal Medicine's "Elements of Professionalism" for Undergraduate Ethics Education" in *Acad Med*. 2002 Jun;77(6):523-31; Batalden P, Leach D, Swing S,

professionalism by this official accreditation board occurred the same year the American Medical Association added the requirement that a physician "shall uphold the standards of professionalism" in the 2001 Revision of its *Code of Medical Ethics*.[15] These developments mark a significant milestone in the restoration of the belief in professionalism in medicine, because they engender the articulation of professional standards in health care, and the cultivation of certain competencies through the practice of professional conducts. The idea of professionalism is closely related to virtue ethics because, as David C. Leach and his co-authors point out, professionalism is a habit that needs to be cultivated through virtuous behavior.[16]

Veatch's critique, however, does raise important questions for virtue-based medical ethics.[17] The first question is how to resolve the great *diversity* of medical virtues across time, culture and geography, and the competing ethical theories behind those virtue claims.[18] The second is the question of right conduct and the role of principles in professional life. This chapter addresses these two questions: (i) the universality versus the cultural diversity of virtues; and (ii) the right relationship between

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Dreyfus H, Dreyfus S., "General Competencies and Accreditation in Graduate Medical Education" *Health Aff* (Millwood). 2002 Sep-Oct; 21(5):103-11. At http://www.ncbi.nlm.nih.gov/pubmed/12224871. Accessed Feb 17, 2012; Yaszay B, Kubiak E, Agel J, Hanel DP., "ACGME Core Competencies: Where Are We?" in *Orthopedics*. 2009 Mar; 32(3):171.

[15] The 1957 and 1980 versions of the *Code* include references to the *medical profession*, but do not refer to professionalism or professional standards. Texts of the *Code* are available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page? Accessed February 21, 2012.

[16] David C. Leach, Patricia M. Surdyk, and Deirdre C. Lynch discuss the practice of professionalism through the lens of Aristotelian virtue ethics. "Practicing Professionalism" in Sheehan & Parsi (eds), *Healing as Vocation: A Medical Professionalism Primer,* 1-8.

[17] Robert M. in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing: Dordrecht/ Boston/ Lancaster, 1985), 329.

[18] Veatch, "Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics," 331.

virtues and principles. First, this chapter defends the view that, though virtues invariably reflect the culturo-historical specificity of a tradition, within a nature-based teleological virtue theory, certain elements are universally relevant and intelligible across time and cultures. Second, this chapter demonstrates that there is no inherent conflict between virtues and principles, because from a Thomistic perspective, virtues provide the teleological context for moral precepts and norms.[19] As Cathleen Kaveny puts it, law is best understood as "a teacher of virtue," in the sense of providing action-guiding precepts for the formation of virtuous citizens.[20]

The chapter begins with the work of Justin Oakley and Dean Cocking who provide an Aristotelian *eudaimonistic* view of the virtues in professional life. This is related to (but distinct from) Drane's approach, in which the medical virtues are grounded in *patient needs*. Pellegrino and Thomasma propose a virtue ethic based on the medical *community* and its *practice* in light of Alasdair MacIntyre's works. The chapter then discusses James Keenan's nature-based approach which provides a useful basis for the medical virtues. The relationship between principles and virtues is examined through a Thomistic lense. Lastly, the tension between the universality and the cultural specificity of the virtues is discussed with reference to the works of Martha Nussbaum, James Keenan, Grace Y. Kao and Maria Christina Astorga.

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[19] See Daniel Daly, "The Relationship Of Virtues And Norms In The *Summa Theologiae"* in *The Heythrop Journal* (2010), No. 51, 2, p. 214–229.

[20] M. Cathleen Kaveny, "The Limits of Ordinary Virtue: The Limits of the Criminal Law in Implementing Evangelium Vitae," in Kevin Wildes & Alan Mitchell (eds), *Choosing Life*: *A Dialogue on Evangelium Vitae*, (Washington, D.C.: Georgetown University Press, 1997).

1.2. ON THE THEORETICAL GROUNDING OF MEDICAL VIRTUES

Moral philosophers Justin Oakley and Dean Cocking propose an Aristotelian virtue-based professional ethics in which the virtues are grounded in the human good.[21] Aristotle defines the human good or *eudaimonia* as "an *activity of the soul*, in accordance with *virtue* (or excellence), over a *complete life*, with sufficient *external goods*."[22] In light of this, the authors hold that there is an interlocking web of intrinsic human goods (such as courage, integrity, friendship and knowledge) that we need for living a good life.[23] The exercise of these virtues and activities under the guidance of prudence is partly constitutive of the human good, or a flourishing life. Within this teleological context, the authors maintain that to act well in a professional role requires that the professional role be part of a good profession, and a good profession being one that serves an intrinsic human good which we need to live a humanly flourishing life.[24] One such human good is health, because health is central for a good human life. As Aristotle put it, the end of medicine is health.[25] For this reason, medicine is regarded a good profession. A profession is thus defined by its commitment to a key human good that contributes to

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[21] Ibid, 74.

[22] Aristotle, *Nicomachean Ethics*, 1101a 14-16.

[23] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001), 15.

[24] Ibid, 74.

[25] Aristotle, *Nicomachean Ethics* I.i.109a8. Leon Kass expands this definition of the end of medicine to include the well functioning of the human being. Kass, L.R. "Regarding the end of medicine and the pursuit of health" in *The Public Interest*, (1975) 40, 11-42. Reprinted in A.L. Kaplan, H.T. Engelhardt, Jr, & J. McCartney (eds), *Concepts of Health and Disease* (Reading, MA: Addison-Wesley, 1981), 3-30.

human flourishing.[26] Medicine is defined in terms of its commitment to health. This commitment determines both the physician's role and the medical virtues that enable physicians to meet the goal of serving the health of patients.[27]

Health, understood as a key human good that contributes to the good life of the patient, is therefore the foundation of a virtue-based medical ethic. Oakley and Cocking define health in terms of normal biological and psychological functioning; where 'normal' is defined as being within statistical standards.[28] The concept of health lacks specificity, thus it is not easy to specify the exact role of the doctor. As one attempts to specify the doctor's role more precisely, one would go from the general to the concrete, and one's description of the medical profession takes on more of the culturo-historical factors of one's context. There are advantages in taking health as the goal of medicine and as the foundation of medical virtues. First, it affirms the understanding of the profession as one committed to a key human good.[29] For example, medicine is committed to health, as the legal profession is to justice, which is also an integral part of human flourishing. The more central the good is for human flourishing, the more essential is the profession. Defining the normative goal of the profession in this way also helps explain the notion of *betrayal* of the profession or the violation of *professional integrity*. Examples include the Nazi doctors experimenting on detainees; doctors having sexual relations with patients; and doctors putting personal wealth before patient

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[26] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, 75.

[27] Ibid, 92-93. Oakley and Cocking suggest (without explaining in detail) their own list of medical virtues which includes beneficence [sic], truthfulness, trustworthiness, courage, humility, and justice.

[28] Ibid, 76.

[29] Ibid, 79-82.

interests. Second, it establishes in broad strokes what the proper role of the physician is. As members of a profession committed to the service of patient health, doctors have good reasons to reject active voluntary euthanasia on the ground that it violates the proper goal of medicine.[30]

Thus far, we have discussed the Aristotelian *eudaimonistic* structure as the basis of the medical virtues. In my opinion, this is the most adequate theoretical grounding of physician virtues. Let us now examine the works of Drane, Pellegrino and Thomasma which engage the issues specific to medical practice in North America. My focus is on the theoretical basis of their virtue claims, with reference to the Aristotelian structure proposed by Oakley and Cocking.

1.3. JAMES F. DRANE: A PATIENT-ORIENTED VIRTUE ETHICS

James F. Drane in his influential work *Becoming a Good Doctor*, argues for the revival of concepts of virtue and character in medical ethics precisely because of the fiduciary nature of the physician-patient relationship.[31] Historically, medicine has been one among the professions in which members are devoted to a certain type of service to society, while committing themselves to high moral standards for the good of others.[32]

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[30] Ibid, 83-84.

[31] James Drane, *Becoming a Good Doctor*: *The Place of Virtue and Character in Medical Ethics* (Kansas City, MO: Sheed & Ward, 1988), 14-15. From his research on the works of Dr John Gregory, Laurence McCullough highlights Dr Gregory's contribution to the emergence of medicine as a fiduciary profession by promoting professional competence and high moral standards among physicians. Laurence B. McCullough, *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine*, (Dordrecht; Boston: Kluwer Academic, 1998), 6.

[32] Medical historians Robert B. Baker and Laurence B. McCullough maintain that the concept of "the profession" in which members commit themselves to a certain specialized service to society, while adhering to certain self-imposed moral standards is a relatively recent concept, rather than a tradition that

As Sheehan and Parsi explain, the traditional (or sociological) model of medical practice sees medicine as a distinctive expertise that requires a long and demanding training which allows physicians to provide services of great benefit to society. Furthermore, the kind of expertise that physicians acquire from years of training is so complex that a considerable degree of autonomy is given to both the individual physician and the medical profession as a whole. This autonomy is part of an informal contract with society, which involves not only privileges, but also obligations and responsibilities. Among the traditional obligations are the provision of services that might put the care-giver at health risk, the promotion of public health and disease prevention, and the provision of emergency assistance to those in dire need even though they cannot pay.[33] Because of these responsibilities and challenges, character development of the physician has remained a crucial part of the Western medical tradition. As Drane sees it, though the principle-based approach is important because it offers clarity and coherence in decision making, it is inadequate because it leaves out the fundamental moral commitments, attitudes and character which characterize the best physicians. Drane agrees with Veatch's concern, but also rightly points out that the problem is not with *any*

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goes back to the Hippocratic physicians. They argue that the terms "the profession" and "professional ethics" can be traced back to Thomas Percival's *Medical Ethics: Or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* published in 1803. Though I think Baker and McCullough make a strong case in identifying the first usage of these *terms*, it is hard to deny that the *concept* of a group of medical practitioners bound together by certain goals and shared ethical standards, committing themselves to providing medical services was present among the Hippocratic physicians. Baker and McCullough, "The Discourses of Philosophy on Medical Ethics" in Baker and McCullough (eds), *The Cambridge World History of Medical Ethics*, (Cambridge/New York: Cambridge University Press, 2009), 290-291. Cf. Ludwig Edelstein, *Ancient Medicine: Selected Papers of Ludwig Edelstein*, ed. Owsei Temkin and C. Lilian Temkin (Baltimore: John Hopkins University Press, 1967); Tom L. Beauchamp and Laurence B. McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (Englewood Cliffs, NJ: Prentice Hall, 1984), 28-29.

[33] D. Ozar & D. Sokol, Dental Ethics at Chairside: Professional Principles and Practical Applications, 2nd ed. (Baltimore: Johns Hopkins University Press, 2002), cited in Sheehan & Parsi (eds), *Healing as Vocation: A Medical Professionalism Primer,* xi.

virtue theory, but with the "naked" theory of virtue which totally disregards rules and objective principles.[34] The Nuremberg Trials did not discredit virtue theory in all its forms, nor condemn virtue and character development among physicians. The Trials however do highlight the real danger of the moral blindness associated with exclusivist versions of professional ethics that spurn objective standards of conduct and put the profession beyond the reach of public scrutiny.

For this reason, Drane proposes a *middle position* that aims to avoid the problems of both pure virtues and pure rules. Because physicians are bound to higher standards of professional conduct, they are called to higher virtues, and to make a greater effort in character formation.[35] Drane develops a patient-oriented ethic which grounds the physician's virtues in patient needs. As Drane sees it, medicine is already a philosophical vision with its own orientation ingrained in the essential acts of diagnosis, therapy, function restoration, pain management and care. Because medical acts have a recognizable structure, certain habitual behaviors can be identified which enable doctors to perform these acts well and meet "the nearly universal expectations" of persons who are ill.[36] Drane's virtue theory is based on Aristotle's *ergon* argument in which the good is understood in terms of function. If the doctor's function is to serve the patient's needs, then a good doctor is one who excels in this function. Virtues in medicine are personal and professional excellences that enable doctors to perform their function well on a

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[34] In his writings on decision making in health care, Drane makes use of bioethical principles, such as autonomy, beneficence, justice, sanctity of life, fidelity, truth, which, as he maintains, give direction to clinical decisions and justify them. "A Methodology for Making Ethical Health Care Decisions," in *Health Progress* (October 1986), 36-37, 64; Clinical *Bioethics: Theory and Practice in Medical Ethical Decision-Making*, (Kansas City, MO: Sheed & Ward, 1994), 52-55.

[35] Drane, *Becoming a Good Doctor*, 18.

[36] Ibid, 19-20.

consistent basis. As he puts it, "The good doctor becomes good by developing those traits and habits which correspond to the specific needs of sick persons. The way illness is lived by patients and the needs it creates in them serve as the objective guide for a good doctor's character development."[37] Drane describes six dimensions of the physician-patient relationship: medical, spiritual, volitional, affective, social, and religious. Corresponding to these are six virtues that would enable the doctor to respond better to patient needs: benevolence, truthfulness, respect, friendliness, justice, and religion.[38] Drane claims that these virtues are grounded in patient needs which are in some sense "universal." However, Drane's description of the meaning and practice of each virtue reflects the cultural context of North America. Drane's insightful expositions of the medical virtues, which I now outline, serve as a helpful illustration of the way the central concerns of contemporary health ethics can be addressed using the language of virtue.

1.3.1.1. James Drane: The Medical Virtues

In Drane's view, first among the medical virtues is benevolence, which refers to the way doctors perform the acts of diagnosis and treatment, applying their specialized skills to the service of patients. Benevolence is the virtue corresponding to the principle of *beneficence*, which refers to specific forms of *doing good* that are peculiar to medicine: to cure disease and relieve pain, to restore functions and care for the patient. Beneficence has its roots in the Hippocratic Oath, which refers to *the way* the physician ought to use medical knowledge and skills, "I will apply dietetic measures for the benefit of the sick

[37] Ibid. 20.

[38] Ibid. 23-24.

according to my ability and judgment; I will keep them from harm and injustice."[39] The Oath acknowledges the physician's specialized skills and demands that physicians put their skills to correct use, namely, for the benefit of patients. According to the Oath, this is the proper end of medicine, and it ought to be the fundamental commitment of the physician who takes the Oath. [40] In *The Art*, another part of the Hippocratic corpus, medicine is defined in this way, "In general terms, it is to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless."[41] This passage defines the goals of medicine, thus the role of the physician: to treat diseases, to reduce patient sufferings, to care for patients. It acknowledges the limitations of medicine, and also the limitations of the physician's role. The physician ought to judge whether medical interventions can offer a reasonable chance of cure or improvement in each case. In yet another part of the Hippocratic Corpus, the *Epidemics*, the physician's duties are summarized as, "Declare the past, diagnose the present, foretell the future; practice these acts. As to disease, make a habit of two things – to help, or at least, to do no harm."[42] This last instruction is closely related to the duty of beneficence, that is, the way physicians ought to use their acquired medical skills.

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[39] *Hippocrates The Oath: Introduction, Commentary and Interpretation* by Ludwig Edelstein (Chicago: Ares Publishers, 1979), 3.

[40] Beauchamp and McCullough, *Medical Ethics: The Moral Responsibilities of Physicians*, 29.

[41] Hippocrates, "The Art" in *Hippocrates*, trans. W. H. S. Jones, Vol II, (Cambridge: Harvard University Press, the Loeb Classical Library, 1923), 193. Quoted in ibid, 30.

[42] Hippocrates, "Epidemics" in *Hippocrates*, trans. W. H. S. Jones, Vol I, (Cambridge: Harvard University Press, the Loeb Classical Library, 1923), 165. Quoted in Beauchamp and McCullough, *Medical Ethics: The Moral Responsibilities of Physicians*, 30.

If beneficence refers to the performance of medical acts to benefit patients, *benevolence* is the virtue which disposes the doctor to carry out these medical acts for the good of each patient under care.[43] In Drane's view, benevolence is the cardinal virtue in medicine, for it refers to *willing the good* of the other, which in medicine means the physician's personal commitment to the good of each patient. This commitment is expressed in the manner in which the physician performs medical acts in response to the patient's needs. It is precisely this personal commitment to the individual person that helps counteract the increasing dehumanizing tendency in modern medicine.[44] Drane insists that the personal dimension of the doctor-patient relationship is not only ethically significant, but also plays a crucial role in determining patient outcomes.[45] The virtue of benevolence disposes the doctor to a *relationship* with the person, whose lived experience of illness includes not only physical symptoms, but also emotions in response to illness. The benevolent doctor is more attentive to this lived reality, and is more likely to make a human and objectively correct diagnosis. Drane describes benevolence in terms that resonate with John Gregory's description of empathy, "Benevolence creates openness to the patient's lived experiences and interest in what the patient has to say about his illness… he takes an interest in the way the patient reacts to this pain or lives a particular diagnosis."[46] Benevolence disposes the doctor to enquire into the patient's personal concerns and emotions connected with the patient's illness. For this very

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[43] Drane, *Becoming a Good Doctor*: *The Place of Virtue and Character in Medical Ethics*, 32-33.

[44] A most articulate critic of this dehumanization is Michel Foucault in *The Birth of the Clinic: An Archaeology of Medical Perception,* tr. by A. M. Sheridan Smith, (New York: Pantheon Books, 1973).

[45] Subsequent research has confirmed the validity of Drane's claim. See footnote 13 above.

[46] Ibid, 35.

reason, benevolence not only makes ethical sense (because it humanizes both the physician and the patient), it also makes good medicine.[47] Benevolence is even more important for persons with chronic illness, such as chronic obstructive pulmonary disease, diabetes, cancer, or AIDS, where the illness becomes integrated into the patient's lifestyle and becomes part of self-experience. With chronically ill patients, benevolence in the physician becomes a crucial element of effective medicine. Without forming a personal relationship with chronically ill patients, the doctor will neither understand their chronic illness nor be able to treat them effectively, and both physician and patient will become miserable. Benevolence is especially required in the cases of chronic illness because it engenders trust and collaboration, two essential elements in the management of long term illness.

Contrary to benevolence is the vice of avarice, the exclusive concern for monetary gain and disregard for patient welfare.[48] The danger of physicians putting self-interest above patient care is undoubtedly a major concern shared by medical associations and medical ethicists alike. The American Medical Association's *Code of Medical Ethics* prescribes, "A physician shall be dedicated to providing competent medical care, with

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[47] *The New York Times* printed a series of articles (Doctors Inc.) beginning from March 2011 to identify the current shifts in medical practice. It has found that more doctors are now abandoning traditional "solo" practice and either work in group practices or take salaried jobs at medical institutions, where they work less hours and receive higher salary. Medical practice is becoming less personal and more "proficient," with physicians spending far less time with patients. Psychiatrists are more likely to prescribe drugs instead of providing counseling, because of the time constraints. Despite the current shifts and the drive for proficiency in medicine, patients continue to value the personal interaction with their physicians. See Gardiner Harris, "Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy" March 6, 2011, on page A1 (NY ed); "More Physicians Say No to Endless Workday" April 2, 2011, page A1 (NY ed); "Family Physician Can't Give Away Solo Practice" April 23, 2011, page A1 (NY ed). See also "A Profession in Transition" *The New York Times*, April 22, 2011.

[48] Ibid, 39-40.

compassion and respect for human dignity and rights," and "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."[49] The World Medical Association explicitly warns the physician "not allow his/her judgment to be influenced by personal profit or unfair discrimination," and "not receive any financial benefits or other incentives solely for referring patients or prescribing specific products" and "be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity."[50] While these *Codes* specify appropriate physician conducts using largely the language of principles (though they also refer to *compassion* and *respect*), Drane addresses these same issues using the language of virtue, which refers specifically to the interior motives behind physician conduct. The advantage of the language of virtue is that it allows a deeper engagement with the personal dimension of the clinical relationship, which would otherwise be perceived superficially at the level of external behavior.

The second in Drane's list of virtues is truthfulness in medical communication. Good communication allows patient involvement in medical decisions, and it requires sensitivity to the needs and interests of the patient. The quality of the doctor's communication is influenced by the virtue of benevolence for it reflects the human relationship with the patient, by which the doctor responds to the communicated needs

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[49] The American Medical Association, *Code of Medical Ethics*, Principles I & VIII, adopted June 1957; revised June 1980; revised June 2001. At http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page? Accessed Feb 15, 2012.

[50] World Medical Association, *International Code of Medical Ethics.* Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983and the WMA General Assembly, Pilanesberg, South Africa, October 2006. At http://www.wma.net/en/30publications/10policies/c8/index.html. Accessed January 31, 2011.

and concerns of the patient. The virtue of truthfulness disposes the doctor to communicate with patients adequately so as to meet their needs. As discussed previously, clinical research in recent decades has shown that good communication with patients is notably associated with better health results, [51] while training in communication skills to improve physician-patient interaction has been shown to improve patient participation and satisfaction.[52] In line with Drane's concern, the Accreditation Council for Graduate Medical Education (ACGME) includes "interpersonal and communication skills" among the core competencies required of medical residents.[53] Furthermore, Drane also sees the sacral character of physician communication. When the doctor speaks truthfully to the patient, what the doctor says "creates a reality for the patient" and the doctor "exercises power over that reality."[54] Because what the doctor says has the power to change the patient, Drane insists that more attention should be given to communication and the cultivation of truthfulness. Good communication also involves attentive listening, and at times respectful silence.

Physician honesty is a significant concern among bioethicists and medical associations, because it is the basis of a trusting relationship between patient and physician. In addition, honesty when performing a professional role also helps uphold

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[51] See Franks, P., Jerant, A. F., Fiscella, K., Shields, C. G., Tancredi, D. J., & Epstein, R. M., "Studying Physician Effects on Patient Outcomes: Physician Interactional Style and Performance on Quality of Care Indicators" in *Social Science and Medicine, 62,* (2006), 422–432.

[52] Kelly B. Haskard, Summer L. Williams, M. Robin DiMatteo, Robert Rosenthal, Maysel Kemp White, and Michael G. Goldstein "Physician and Patient Communication Training in Primary Care: Effects on Participation and Satisfaction" in *Health Psychology*, (2008), Vol. 27, No. 5, 513–522.

[53] The ACGME website under "Core Competencies" (2001), at http://www.acgme.org/acwebsite/RRC_280/280_corecomp.asp. Accessed February 17, 2012.

[54] Drane, *Becoming a Good Doctor*, 53.

the public trust in the profession. There are good reasons why the American Medical Association exhorts physicians to "be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."[55] Similarly, the World Medical Association prescribes that physicians "deal honestly with patients and colleagues," and report to the appropriate authorities physicians who deviate from professional standards and norms.[56] From a virtue ethics perspective, Drane identifies truthfulness as a foundational element of character, and believes that it is related to a certain way of being. The virtue of truthfulness not only engenders trust and collaboration between physician and patient, but also contributes to the physician's character stability and inner strength. The habit of telling the truth not only strengthens the public trust in the profession, but also confirms the physician's integrity. On the contrary, deceit and lying undermine both the stability and identity of a person. The virtue of truthfulness makes the doctor dependable.[57]

For Drane, truthfulness ought to be coordinated with benevolence. The benevolent physician shows consideration and sensitivity when speaking the truth to patients and their families. The virtue of prudence is also important to make truthfulness truly beneficent for the patient. As Drane puts it, "Truth telling in disregard of benevolence can destroy a patient, while an exaggerated benevolent concern for the patient's welfare can erode both truthfulness and the doctor's character."[58] Truthfulness

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[55] The American Medical Association, *Code of Medical Ethics* (Revised 2001), Principle II.

[56] World Medical Association, *International Code of Medical Ethics* (Amended 2006), "Duties of Physicians in General."

[57] Drane, *Becoming a Good Doctor*, 57.

[58] Ibid, 59. This is much in line with Aquinas's emphasis that the application of moral precepts requires the

particularly gives a depth and firmness to the doctor-patient relationship as well as to the doctor's character.

The third is the virtue of *respect,* which helps safeguard patient participation when it occurs.[59] Drane defines respect as the "trained attitude to reverence those free acts by which patients carry out their best interests."[60] It is the right regard for the other's capacity to choose his or her own ends. This virtue corresponds to the principle of respect, which is expressed as the demand for *informed consent* in the Nuremberg Code and the Declaration of Helsinki.[61] The Belmont Report more specifically identifies two elements of the principle of respect for persons: "the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy."[62] The document explains that to respect autonomy is "to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others." The document recognizes that some persons are "in need of extensive protection," while other persons "require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequence." Recall that during the Nuremberg Trials, the state of vulnerability created

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exercise of the virtues, especially the exercise of prudence. For more discussion on the relationship between the virtues and principles/ norms, see section 1.3.2.

[59] Ibid, 63-64.

[60] Ibid, 64.

[61] The Nuremberg Code (1947), Par. 1. At http://ohsr.od.nih.gov/guidelines/nuremberg.html. Accessed Feb 24, 2012. World Medical Association: Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects, Principles 11 & 26. At http://www.wma.net/en/30publications/10policies/b3/. Accessed Feb 24, 2012.

[62] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research: The Belmont Report - Ethical Principles and Guidelines for the Protection of Human Subjects of Research (April 18, 1979), Part B, no.1. At http://ohsr.od.nih.gov/guidelines/belmont.html. Accessed Feb 1, 2011.

by the power imbalance between the clinician and the patient was the prime concern. The Nuremberg move was to restrict physician's power by emphasizing patient's *informed consent* in order to protect patients and research subjects in their state of vulnerability. Since Nuremberg, a benchmark has been established for any approach to biomedical ethics: whether it can adequately address this power imbalance and the state of vulnerability of patients. Drane's basic claim is that, by adopting a *middle position*, he does not deny the necessity of principles, including the principle of respect for autonomy. However, from a virtue ethics perspective, Drane's primary emphasis is the formation of the virtuous character of physicians who exercise the medical power. Drane believes that virtue and principle can complement each other, because the virtue of respect is gained through the repeated *exercise of respect* in dealing with others.

Drane agrees with Kant's view that respect for autonomy is the proper response to the essential freedom of the human being. In health care, Drane believes respect is an essential virtue for the physician *because* it is essential for human development. [63] It recognizes each individual as a free and self-determining subject. Respect engenders human association, and is also linked with other basic values such as benevolence, kindness, and justice. In Drane's view, respect for patient choice must be understood in the context of benevolence and truthfulness.[64] A respectful doctor does not see the

[63] Drane's virtue theory involves a certain view of human flourishing, which provides context for the virtues. For this reason, I believe that Drane's theory is well aligned with the Aristotelian eudaimonistic virtue theory, as proposed by Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001).

[64] Drane, *Becoming a Good Doctor*, 65.

patient as a mere number or a physical problem that needs fixing. A good doctor helps and respects those who are weak and defenseless, and refrains from exploiting them.[65]

The current debates on bioethical issues such as abortion and physician-assisted suicide often highlight two fundamental approaches to medicine: the beneficence model, and the autonomy model.[66] Where clinical decisions involve a conflict between beneficence and respect for autonomy, Drane believes that physicians ought to choose beneficence, for it is the highest value in medicine. He argues that each profession has its own basic ethical principle that must be safeguarded. In his view, beneficence – to do what is in the patient's best medical interest – is the constitutional principle of medicine. For this reason, beneficence cannot be allowed to be undermined by other values, such as autonomy. To promote patient autonomy at the expense of beneficence is logically indefensible, because it would amount to obligating doctors to do what they believe to be of no benefit or actually harmful to patients.[67] Beneficence ought to function as the primary principle, and respect for autonomy should shape and set limits to this primary obligation, but never contradict it. The patient's personal beliefs and ends are important factors to be included in the consideration of physician obligations, which are generated

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[65] Ibid, 69.

[66] The beneficence model, with its philosophical roots in the Hippocratic writings and the works of Dr John Gregory, understands the moral end of medicine as the promotion of the patient's best *medical* interests, and takes the principle of beneficence as its sole fundamental principle. The physician is required to promote the goods for patients and to avoid harms to them, as medicine defines those goods and harms. The autonomy model, developed in legal contexts with philosophical roots in the works of John Locke and Immanuel Kant, understands the end of medicine as the promotion of the patient's best interests as determined by the *patient's autonomous decisions*. This model takes the principle of respect for autonomy as the sole fundamental principle, and requires the physician to promote goods for patients, as their autonomous preferences define those goods. For more details on these models, see Tom Beauchamp and Laurence McCullough, *Medical Ethics: The Moral Responsibilities of Physicians*, (Englewood Cliffs, NJ: Prentice Hall, 1984), 26-51.

[67] Drane, *Becoming a Good Doctor*, 72.

primarily by beneficence. Furthermore, Drane believes that the balance between respect and beneficence can shift as the patient moves from acute to *chronic* illness. As this movement occurs, concerns for the patient's best medical interest weigh less, while patient preferences weigh more. A similar shift ought to occur also with a dying patient. Again, with the end-of-life issues, Drane's emphasis is on the priority of beneficence over autonomy if medicine is to retain its integrity and to serve society.[68] There are just limits to what respect for autonomy can demand: standards of good medical practice; the effects of patient's choices on others; and the interest of the state.[69]

The fourth in Drane's list is the virtue of friendliness, which refers to the affective dimension of the doctor-patient relationship. Though affection does not always develop in a medical encounter, physicians do encounter many strong (positive or negative) feelings from patients, to which they ought to be able to respond appropriately. The virtue of friendliness disposes the doctor to the right relationship with the patient, avoiding both coldness, which Drane considers a vice, and excessive affection which can spill into an erotic involvement that is destructive of therapy and violates the professional role. Friendliness helps preserve appropriate boundaries between physician and patient. The appropriate medical friendship is one between persons who are involved in a common project.[70] Drane argues that because friendship is the affective aspect of benevolence, it remains both an ideal and an obligation even for modern physicians, because at times patients do need affection. Illness causes the kind of isolation that only

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[68] Ibid.

[69] Ibid.

[70] Ibid, 82. This is in line with the precept that physicians ought to "Approach health care as a collaboration between doctor and patient" in the Australian Medical Association's *Code of Ethics* (2004, revised 2006).

the doctor can relieve. For Drane, the virtue of friendliness disposes the doctor toward a healthy affectionate relationship and helps the practitioner to control the hostile forces within.

Though the language of friendship with a patient is hardly familiar in contemporary health practice, in classical philosophy friendship is closely linked with benevolence as Drane points out. Plato defines love as to will the other's happiness (*Lysis* 207D).[71] In Aristotle's view, the love for a friend is distinctive in that one *wishes good* to a friend "for his sake" (*Nicomachean Ethics*, 1155b31). Upon the background of Greek cultural understanding of *philia* as the "unifying principle of relationship and harmony," Aristotle presents mutual friendship as the central case of *philia*. He defines friends as persons who are "mutually recognized as bearing goodwill and wishing well to each other" (1156a3-5).[72] Within a medical relationship where the physician wishes the good of the patient, and is willing to act on that goodwill for the patient's sake, certain vital elements of friendship do exist. However, the crucial difference between Aristotle's understanding of friendship and the physician-patient relationship is the mutuality between friends. Perhaps, in a qualified sense, the collaborative relationship between the physician and the patient can be regarded as a form of friendship. Drane's point in including friendliness among the medical virtues is to emphasize the affective dimension of this relationship. Furthermore, against the impersonal nature of contemporary health

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[71] Liz Carmichael, *Friendship: Interpreting Christian Love* (London/New York: Continuum, 2004), 16. Similar to Carmichael, Stephen J. Pope explains that from an Aristotelian-Thomistic perspective, friendship is the paradigm of Christian love. Pope defines friendship as love of the other person for that person's own sake, taking the good and evil that the person experiences as one's own. See his article "Christian Love as Friendship: Engaging the Thomistic Tradition" to be published as a chapter in a *festschrift* for Gene Outka. Chestnut Hill, MA: Boston College, 2011.

[72] Carmichael, *Friendship: Interpreting Christian Love,* 16.

care, he insists that therapy ought to take place within a genuine human relationship between two persons. Similar to Drane, advocates of care ethics have emphasized the relational dimension of a range of helping professions, including psychological counseling, social work, and nursing.[73] In Mel Gray's words, the ethics of care "emphasizes the relational embeddedness of care," which is well in line with the recognition in social work that relationality is a constitutive part of being human. [74] Gray refers to "the care-giving relationship," which is the normative context for social work. Drane's stress on the relational dimension of medical care is well grounded in virtue ethics, especially the Aristotelian *eudaimonistic* ethics in which friendship is an indispensable part.

The fifth is the virtue of justice, which Drane discusses in terms of the *physician's obligations* to the wider society.[75] He explains that the doctor-patient relationship is essentially social, and illness itself invariably has a social dimension, the corresponding virtue ought to be justice.[76] Drane is an uncommon health ethicist who in the 1980s stressed the social determinants of health and illness. Before the scourge of the AIDS pandemic, Drane already pointed out that many illnesses were at least partly caused by

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[73] See Nel Noddings, *Caring: A Feminine Approach to Moral Education*, (Berkeley: University of California Press, 1984); Rosemarie Tong, "The Ethics of Care: A Feminist Virtue Ethics of Care for Health Practitioners" in *Journal of Medicine and Philosophy* (1998), Vol 23, No. 2, 131-152; Annmarie Mol, *The Logic of Care: Health and the Problem of Patient Choice*, (London: Routledge, 2008).

[74] Mel Gray, "Moral Sources and Emergent Ethical Theories in Social Work" in *British Journal of Social Work* (2010) 40, 1794–1811.

[75] Most often, bioethicists discuss justice in health care in terms of distributive justice, and how various theories of justice can influence the way we interpret just distribution of care See for instance Beauchamp and Childress, *Principles of Biomedical Ethics* 5th ed, 225-282; Allen Buchanan, "Justice: A Philosophical Review" in Earl E. Shelp (ed), *Justice and Health Care*, (Dordrecht/Boston/London: Reidel, 1981), 3-22.

[76] Drane, *Becoming a Good Doctor*, 94-98.

social factors.[77] In his view, equitable access to medical care is a justice issue that ought to be included among the concerns of a good doctor. In 1975, William F. May in his influential article emphasized the doctor's indebtedness to society as a basis for the covenant relationship between doctor and patient. In the same vein, Drane stresses that doctors are educated at great social expense, and are bound by justice to work toward equitable distribution of health care.[78] Furthermore, because doctors exercise a considerable social power as a result of their education, they ought to use this power to benefit the more disadvantaged in society.[79] Drane outlines the widening gap in health access between the rich and the poor, the numbers of persons in America that have no access to care, and the medical experiments that exploit the poor only to benefit the rich. Facing these huge challenges, doctors ought to cultivate the virtue of justice which will dispose them to action on behalf of the poor. Though doctors alone cannot solve the problem of health care for the poor, Drane believes that "no solution will ever be found which does not include physicians."[80] In light of such enormous challenges, the cultivation of the virtue of justice among doctors is of paramount importance. According to Drane, doctors have a privileged position within society, which comes from their specialized knowledge and capability. Within a contemporary knowledge-driven society,

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[77] For a discussion of the social causes of illness related to HIV/AIDS, see James F. Keenan (ed), with Jon Fuller, Lisa Sowle Cahill and Kevin Kelly, *Catholic Ethicists on HIV/AIDS Prevention*, (New York/ London: Continuum, 2005).

[78] William F. May stresses that, because of the physician's indebtedness to society, there is an implicit "covenant" that the doctor enters into for service to the community. See, "Code, Covenant, Contract, or Philanthropy" in *The Hastings Center Report*, Vol. 5, No. 6 (Dec., 1975), 29-38.

[79] Drane, *Becoming a Good Doctor*, 96.

[80] Ibid.

doctors ought to be aware of the power that they exercise – or can exercise – and the social responsibility associated with it.[81]

In explaining his understanding of justice, Drane points to the innate sense of fairness in each person which is expressed in the classical philosophical definition "giving to everyone his due." While questions on the *concept* of justice would stimulate ongoing debates and formulations, the *sense* of justice is readily accessible to all. For doctors, the virtue of justice disposes the doctor to "concrete acts of giving what is due to patients."[82] In light of Rawls' theory of justice,[83] Drane maintains that doctors with a commitment to social justice will have to work to "rebalance an unequal system," and to "compensate" those who have less.[84] Drane proposes physician action for social change to begin at the level of micro allocation. At a higher level, Drane urges doctors to use their social clout to promote, or at least not to obstruct, health care access of the less advantaged. [85]

According to Drane, the virtue of justice is derived from the social dimension of the doctor-patient relationship, but ultimately it is rooted in the nature of the human person. Human beings need certain basic goods in order to maintain their dignity. Within the context of vast inequality, the virtue of justice begins at home in favor of poor

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[81] Ibid, 104.

[82] Ibid, 107.

[83] John Rawls, *A Theory of Justice*, (Boston, MA: The Belknap Press of Harvard University Press, 1971).

[84] Drane, *Becoming a Good Doctor*, 107.

[85] Ibid, 108. In line with this, A.G. Wallace maintains that the training of tomorrow's doctors ought to be directed toward a public goal, and to form professionals who see medicine in a broader social context. "Educating tomorrow's doctors: the thing that really matters is that we care" in *Academic Medicine*. 1997 Apr; 72(4): 253-8.

patients. Drane believes that doctors can be more just in their offices, hospitals, and in greater involvement with social services in their community. Doctors ought to begin to work for change from the grassroots level up.[86]

Drane rightly identifies the issue of access to medical care as a social justice issue. He is also right in identifying the virtue of justice is that which predisposes the physician to act for more equitable distribution of health care. However, his discussion in this section reveals the limitations of the traditional framework of medical ethical discourse – the physician-patient relationship – as the context for addressing the social justice concerns.[87]

The sixth and final in Drane's list is the virtue of religion. Drane points to the historical link between religion and medicine, between the priestly roles and healing in both Hebrew and Greek cultures. The Hippocratic Oath, for instance, contains moral precepts very similar to priestly virtues: to keep both one's life and art pure and holy; to avoid doing harm to patients; to abstain from immoral acts especially sexual acts in relation to the healing practice; and to keep information about patients secret.[88] As Drane points out, the more traditional codes of medical ethics reflect two sides of medicine: the high ethical standards of the priestly tradition, and the provision of medical services for

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[86] Ibid, 110.

[87] On this point, Cahill maintains that the contextual analysis of health care decisions is inadequate if it still maintains a patient-focused approach, and a more adequate theological bioethics ought to foster a commitment to both *human dignity* and the *common good*. See Lisa Sowle Cahill, *Bioethics and the Common Good: The Pere Marquette Lecture in Theology 2004* (Milwaukee: Marquette University Press, 2004); Cahill, *Theological Bioethics: Participation, Justice, and Change* (Washington DC: Georgetown University Press, 2005).

[88] Drane, *Becoming a Good Doctor*, 114.

monetary gain.[89] Drane believes that the "priestly" tradition in medicine is the origin of both the idealism of selfless service and the demands for social privileges.

Drane's explanation of the virtue of religion falls into three categories: care of the dying, "religious" belief and altruism in medicine. First, at the time of death, patients frequently face the painful experience of despair when physical disintegration is imminent. The religious dimension may either be expressed as hope for a future good, or the courage to die in despair.[90] At this liminal experience, human beings become religious, in the sense of belief in something more, or the belief that there is nothing more. Both theism and atheism are *religious* stands, because neither is derived from scientific evidence. In Drane's view, doctors can assist the dying patient by standing close by, and to attend to the patient's religious needs in either case. Second, Drane refers to the physician virtue of religion in terms of religious belief, which represents "the inner willingness to offer oneself in the service of God."[91] Drane insists that, for the believing doctor, the traditional understanding still applies. For doctors who do not think of themselves as religious in a traditional sense, the virtue of religion in the expanded sense would involve the recognition of the "transcendent" in the patient; and the commitment to serving patients as they struggle with questions of meaning.[92] The virtue of religion adds a sense of reverence to medical acts, and guards the doctor against treating patients mechanically. Like all other medical virtues, the virtue of religion is related to beneficence, and directs the doctor to meet patient needs. Third, Drane

[89] Ibid.

[90] Ibid, 127.

[91] Ibid, 128.

[92] Ibid.

understands religion as altruism which in medicine means serving patients rather than self-serving. The virtue of religion is compatible with patient-centered medicine, and helps guard doctors against both selfishness and idolatry.[93] In Drane's view, the virtue of religion essentially refers to the disposition to reverence and to serve the other.

It seems that Drane both draws upon Aquinas' understanding of the virtue of religion (*Summa Theologiae*, IIa-IIae, q81) and modifies it for today's pluralistic context. Within Aquinas' theological ethics, the virtue of religion "denotes properly a relation to God" Who is our "unfailing principle" and "our last end," to Whom we ought to be bound (IIa-IIae, q81, a1). For Aquinas, religion is a virtue because it predisposes its possessor to render to God what is due, that is, to pay due honor to God, and through "being ordered to him in a becoming manner" (IIa-IIae, q 81, a2). In light of Drane's patient-oriented approach, religious needs in patients can be considered among the core patient needs to which physicians ought to be able to respond appropriately. Though I find Drane's reference to the "priestly role" of doctors dated and unfitting for a contemporary context, I think Drane rightly identifies religion as an important part of patient care, because religion is what gives meaning, direction, comfort and strength to many patients in times of crisis. This is clearly a delicate issue, because it relates to the freedom of religion of both the patient and the physician. For this reason, Drane treats it carefully, without over-asserting the point on the personal religious conviction of the physician. In terms of responding to patients' religious needs, the principle of respect requires that physicians do not impose their religious convictions, either theism or

[93] Drane, *Becoming a Good Doctor*, 129.

atheism, on their patients, nor discriminate them on religious grounds. Beyond this respectful distance, Drane encourages a more positive engagement with patient's religious needs as part of total patient care.[94] A related issue which Drane does not discuss is how religious faith can at times impede medical care. Occasionally, the faith-related convictions of parents toward sickness and healing can prevent life-saving medical help for sick children, and put young lives at risk.[95] In certain cases, legal intervention may be necessary to protect the lives of children. Nevertheless, a physician who shows a respectful attitude toward religious faith can help the parents – and sometimes patients – work through their reservations about medical care.[96]

1.3.1.2. Drane's Subsequent Writings on Medical Virtues

In his later works, Drane continues to justify physician character and virtues in view of patient needs. [97] While acknowledging the cultural differences that give rise to different conceptions of physician character and virtue, he believes that there are "nearly universal similarities in the way human beings become ill and seek help from healers." Because of these widespread similarities, it is intelligible to speak of a "near universal model" of

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[94] An example of this engagement is given by Dr. Horace E. Smith, MD, who serves as both a pediatric hematologist/ oncologist and a Pentecostal bishop. Dr. Smith said that he does not mention faith as a matter of fact, but "I let people talk to me about their life and their hopes and their faith." See Damon Adams, "Faith in Healing: A Chicago physician is as at home in the pulpit as he is in the exam room." Posted Dec 27, 2004, at http://www.ama-assn.org/amednews/2004/12/27/prsa1227.htm. Accessed Feb 15, 2012.

[95] See S.M. Asser & R. Swan, "Child Fatalities From Religion-Motivated Medical Neglect" in *Pediatrics* 1998 Apr;101(4 Pt 1):625-9.

[96] Alicia Gallegos gives the example of pediatrician Dr. James Lace who is influential in persuading the parents of a 15 year old asthma patient to accept medical care, by discussing Bible passages about healing, and even prayed with them. "Miracle vs. Medicine: When Faith Puts Care at Risk" posted Sept 19, 2011, at http://www.ama-assn.org/amednews/2011/09/19/prsa0919.htm. Accessed Feb 28, 2012.

[97] James F. Drane, "Character and the Moral Life: A Virtue Approach to Biomedical Ethics" in Edwin R. Dubose, Ronald P. Hamel & Laurence J. O'Connell (eds), *A Matter of Principles?: Ferment in U.S. Bioethics*, (Valley Forge, Pa.: Trinity Press International, 1994), 284-309; *More Humane Medicine: A Liberal Catholic Bioethics* (Edinboro, Pa.: Edinboro University Press, 2003).

what a good doctor is like.[98] Drane believes that, based on the internal structure of medical practice, specific physician virtues may be identified, though these may not be expressed in the same way in every culture.[99]

Within these variable circumstances, however, Drane asserts that "people of all ages and cultures expect their healers to be gentle, caring, and concerned primarily for them." They expect the physician to be respectful, to care for them in a personal way, to be honest, to be unselfish, and to be friendly. Furthermore, real caring requires courage in order to endure exposure to health risks, for instance, in the care of AIDS patients. Another important virtue is prudence, the habit of discernment and careful appraisal, making use of one's lived experience. Furthermore, Drane discusses certain medical virtues in connection with the "priestly role" of physicians: confidentiality in regard to patient's private information, purity and uprightness in character, and humility in the exercise of authority over people's lives. In addition, Drane believes hope is a necessary virtue that enables the physician to stand by the patient and to assist in the face of serious illness and death. For persons of religious faith, the good doctor provides hope because diminishment and death do not have the final say. For nonreligious patients who face death, it is the hope that death will come without unnecessary pain and suffering, and the good doctor has the ability to provide this hope and assistance.

Drane acknowledges that "the virtues most characteristic of medical practice do undergo change over time," and that "different social, cultural, political, and economic situations have an impact on the doctor-patient relationship and require adjustments in

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[98] James F. Drane, "Character and the Moral Life: A Virtue Approach to Biomedical Ethics", 297.

[99] Ibid, 301.

medical ethics."[100] Recall that Veatch makes use of the same observation in his argument about the futility of trying to find a list of acceptable virtues in a pluralistic society. James Drane sees the context-dependent nature of the medical virtues as the reason to constantly readjust one's view of the virtues, so as to respond appropriately to patient needs. Though people's experience of illness is in some sense universal, the way patient needs are met is determined by particular factors that exist within concrete historical contexts. From this theoretical perspective, the fundamental ideas of character and virtue in medical care remain intelligible across time, cultures and geography, while concrete expressions of the medical virtues would reflect the particularities of the context in which medicine is practiced.

Significantly, Drane maintains that the most flagrant moral failures among physicians today, such as physicians taking advantage of patients financially or sexually, are instances of character failures more than rule violations. The abandonment of character considerations in medical codes of ethics, and from medical school training, can contribute to these moral failures among physicians. The increasing marginalization of religion, which once played a significant role in the ethical formation of persons within society, can explain the neglect of character and virtue in professional life. Though they may neglect these traditional concepts, no one can escape the task of forming one's moral self. In this lies the deficiency of pure-rule approaches to medical ethics.[101]

To sum up, Drane maintains that all virtues inherent in medicine are grounded in friendliness. It is also the key to good medicine. In response to the widespread bio-

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[100] Ibid, 302.

[101] Ibid, 303-305.

technological approaches to medicine, Drane maintains that when therapy is required, it ought to occur within a human relationship between two persons. The physician-patient relationship is so important to the patient that the efficacy of any form of therapy will be influenced by the quality of that relationship. Instead of adapting into the culture of "stranger medicine," physicians ought to be aware that unfriendliness is a medical vice which represents a core deficiency. Because "the doctor's character is the first medicine" being provided to the patient, it is necessary to pay more attention to character and virtue in mainstream biomedical ethics. He calls for an integration of the physician's character into the mainstream principle-based approach, a move that he believes will both enhance biomedical ethics and improve therapeutic efficacy.

In his more recent book, Drane discusses virtue and character under the rubric of more humane medicine. He names competence and compassion, disclosure and patient education, protecting patient participation, and friendship as key features of humane medicine.[102] In view of the patient's suffering and vulnerability, friendship becomes a professional obligation. Though it is not characterized by equality, this friendship involves a real bond of affection, and requires a balance between assisting and respecting the other's freedom.[103]

1.3.1.3. Drane on the Medical Virtues: An Evaluation

Drane proposes a virtue theory in which the virtues are grounded in the doctor-patient relationship. Note that Drane's understanding of the 'doctor-patient relationship' is quite

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[102] James F. Drane, *More Humane Medicine: A Liberal Catholic Bioethics* (Edinboro, Pa.: Edinboro University Press, 2003).

[103] Ibid, 12-4.

distinct from the general use of the term, often as shorthand for a clinical encounter between a doctor and a patient, which is sometimes explained in terms of contract, duties or rights.[104] Drane has in mind a moral personal relationship between two persons, and this is the context in which healing is to take place. In Drane's view, neither diagnosis nor treatment can occur outside a personal relationship between doctor and patient.[105] In other words, Drane envisions a real relationship, though it is often brief, between unequal partners and lacking in mutuality. This doctor-patient relationship is the basis for Drane's virtue claims. It is the context in which the doctor uses specialized knowledge and skills to benefit a patient. It is also the context wherein the doctor cultivates and exercises the virtues. Drane's explanation of the two virtues, benevolence and friendliness, highlights the relational dimension of medicine, and a certain kind of interpersonal bond that is indispensable in medical practice. Drane emphasizes that this personal dimension is humanizing for both physician and patient, and also contributes positively to patient outcomes. In Drane's view, to foster the personal aspect of medicine not only makes good ethical sense, but also makes good medicine. That is Drane's major contribution.

Drane's normative virtue ethic is based upon Aristotle's *ergon* argument which defines the good in terms of function. Applying to medicine, Drane defines the doctor's function in terms of serving the patient's needs, and the good doctor is one who excels in

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[104] See for example Howard Brody, "The Physician-Patient Relationship" in Robert Veatch (ed) *Medical Ethics* (Sudbury, Mass.: Jones and Bartlett Publishers, 1997); Mary Anne Bobinski, "the Physician-Patient Relationship" in Baruch Brody, Laurence McCullough, Mark Rothstein, and Mary Anne Bobinski, Medical Ethics: *Analysis of the Issues Raised by the Codes, Opinions and Statements* (Washington D.C.: The Bureau of National Affairs, Inc., 2001), 635-680.

[105] Drane*, Becoming a Good Doctor,* 24.

this function. Medical virtues are personal and professional excellences that enable doctors to respond well to patient needs on a consistent basis. Drane identifies six dimensions of the doctor-patient relationship – six areas of patient needs – and six physician virtues corresponding to those needs. Patient needs provide the guide for physician character development. In Drane's virtue theory, "patient needs" is a foundational category which helps define the physician's normative role and physician virtues. He distinguishes between patient needs and autonomy-based patient requests. The former is understood to have an objective basis, which is related to the common human experience of illness. For this reason, patient needs are in some sense universal and intelligible across time and cultures.

I find Drane's use of *patient needs* as the foundation for medical virtues to be unsatisfactory, and suggest that Drane's Aristotelian approach would have a better foundation in a related moral category: the human good or *eudaimonia*. The category of "patient needs" is useful in providing proximate ends for identifying physician virtues. However, these needs point toward a more basic good, the attainment of which requires that the person's health needs be fulfilled. Though Drane's discussion of the six areas of patient needs is useful in the delineation of the virtues, there is a significant problem with deriving medical virtues purely out of patient needs without any reference to the proper goals of medicine. A person who is ill has numerous needs, and not all of these oblige the physician to respond to the same degree. For instance, a poor homeless man who presents himself with tuberculosis would need not only physician assistance, but also food and shelter. Though the provision of nutrition and shelter is necessary for the patient's recovery, it would not be within the physician's primary duties to provide for

these basic needs. In other words, the physician's primary duties have to be defined in terms which are other than patient needs. The boundaries between health related needs and other kinds of needs are not sufficiently clear for making deductive assertions about physician virtues without some prior understanding of the goals of medicine and the proper role of physicians.

A more adequate basis for the medical virtues may be found in Aristotle's concept of *eudaimonia*, or human flourishing, which I believe is in line with Drane's trajectory. Implicit in Drane's writings is a certain concept of the human good which provides the *telos* for the medical virtues. He holds that the medical virtues are good because they help improve patient outcomes, *and* also good for the physician who exercises them. For instance, he insists that benevolence humanizes both the physician and the patient; the virtue of truthfulness contributes to physician character stability and inner strength, while respect is thought to enhance both the other and oneself. These assertions are consistent with an Aristotelian virtue theory in which the virtues are defined in terms of a humanly flourishing life. Furthermore, "patient needs" in Drane's theory may be interpreted as the health requirements necessary for a person to live a flourishing life. The human good is thus a more basic category than patient needs, and provides a better telic context for the medical virtues.

Note the two senses in which the medical virtues are said to be good: they are good for the patient, *and* good for the physician. I suggest that in both cases, *eudaimonia* is a more adequate theoretical basis for the virtues. In the second sense, the medical virtues are good because they contribute to the human flourishing of the physician who exercises

them. This highlights the point that virtues in an Aristotelian framework are intrinsic goods because they are integral to *the good* of the agent. In the first sense, the medical virtues are good for the patient because they enable the physician to practice good medicine, and thus contribute to the patient's flourishing. In other words, the good (or *eudaimonia*) of the patient provides the guide for the cultivation of physician virtues, which in turn enable physicians to perform well in their role. This is the area of professional ethics in which the professional's virtues are grounded ultimately in the good of the client or patient. Furthermore, the medical virtues are good in themselves and also contribute to the human flourishing of the health professional who practices them.

1.3.2. PELLEGRINO AND THOMASMA: A COMMUNITY-BASED APPROACH

Subsequent to Drane's book on the medical virtues, Edmund Pellegrino and David Thomasma present a community-based virtue ethics in their book *The Virtues in Medical Practice,* which collates many of Pellegrino's earlier works. The authors begin by asserting that medicine is a moral community, because "it is at heart a moral enterprise and its members are bound together by a common purpose."[106] For this reason, members of the medical profession must be guided by some shared morality that is consistent with the goals of medicine. The authors promote a teleological view of the virtues that is in

[106] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, (New York : Oxford University Press, 1993), 3.

line with the classical definitions of Aristotle and Aquinas.[107] Their understanding of the medical virtues also reflects the influence of Alasdair MacIntyre's *After Virtue*, especially on the concept of community, its tradition, and the communal practices as the context of the virtues.[108]

Against modern attempts to *redefine* the medical profession, or to *replace* the fiduciary relationship with a contractual model,[109] Pellegrino and Thomasma strongly defend the concept of the medical profession as a moral community, whose members are bound together by a common *practice*, the medical art.[110] They write,

> We wish to argue that medicine is at heart a moral community and always will be; that those who practice it are de facto members of a moral community, bound together by knowledge and ethical precepts; and that, as a result, physicians have collective, as well as individual, moral obligations to protect the welfare of sick persons in a world that increasingly treats medicine as a commodity, the political bauble, an investment opportunity, or a bureaucrat's power play. The profession and the public want physicians to be members of a moral community dedicated to something other than self-interest.[111]

The authors maintain that the contractual model is inadequate because medical consultations cannot be reduced to business transactions where services are exchanged for set fees. They list five features integral to medicine that make it distinctive: (1) the

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[107] Ibid, 12.

[108] Ibid, 11-12. Pellegrino subsequently specifies the distinctions between his view and that of MacIntyre in his article, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions" in *Journal of Medicine and Philosophy* (2001), Vol. 26, No. 6, pp. 559-579. See discussion in section 1.3.1.

[109] As Robert Veatch proposes in *A Theory of Medical Ethics* (New York: Basic Books, 1981).

[110] Note that MacIntyre's concepts of *community* and *practice* refer to concrete historical realities, rather than abstract ideas that transcend time and cultures. See discussion below.

[111] Ibid., 33. Robert Veatch argues that medicine is more than doctoring. If medicine is a practice at all, Veatch argues, it is one that is engaged in by professionals and laypersons, nurses, parents and patients, and all rational adult persons who work to restore and/or maintain continued good health. Robert M. Veatch, "Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics" in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing: Dordrecht/ Boston/ Lancaster, 1985), 332.

vulnerability and inequality of the medical relationship, (2) the fiduciary nature of the relationship, (3) the moral nature of medical decisions (4) the nature of medical knowledge, and (5) the ineradicable moral complicity of the physician in whatever happens to the patient.[112] These features are common to other fiduciary relationships: nurse-patient, minister-parishioner, and lawyer-client. The authors maintain that each profession, like medicine, has its own distinctive set of moral imperatives, which gives rise to its *internal morality* and defines the moral nature of its enterprises. [113] Integral to this promotion of the concept of the profession is an idealism of service and sacrifice that was once an essential part of the professions.[114] Because this commitment to service of others is intrinsic to the very concept of a profession, Pellegrino and Thomasma maintain that self-interest, which may be legitimate at the center of a business exchange, "must to a degree be suppressed in the interest of sick-persons," because of the nature of medical activity.[115]

If the medical profession is a moral community defined by a common practice, then the goals of this community are closely linked with the goals of that practice. As

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[112] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 42-44. See also Edmund Pellegrino's paper "The Medical Profession as a Moral Community" presented at the Stated Meeting of the New York Academy of Medicine, November 9, 1989; printed in *Bulletin of the New York Academy of Medicine,* Vol. 66. No.3, May-June 1990, 221-232.

[113] In line with this, Allen E. Buchanan defines a profession in terms of five elements: (1) special knowledge of a practical sort; (2) a commitment to preserve and enhance that knowledge; (3) a commitment to excellence in the practice of the profession; (4) an intrinsic and dominant commitment to serving others on whose behalf the special knowledge is applied; and (5) effective self-regulation by the professional group. Allen E. Buchanan, "Is There a Medical Profession in the House?" in R.G. Spece, D.S. Shimm, and A.E. Buchanan (eds), *Conflict of Interest in Clinical Practice and Research*, (Oxford University Press: New York, 1996), 107.

[114] See, for instance, George D. Lundberg, MD; Laurence Bodine, Esq "Fifty Hours for the Poor" editorial *Journal of the American Medical Association* 1987;258(21):3157. Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001), 81-82.

[115] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 44.

they see it, "the ends of medicine are ultimately the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability."[116] In a later work, Pellegrino provides a simpler formulation, "The purpose of the physician-patient relationship is healing, i.e., curing when possible, caring always, relieving suffering, and cultivating health."[117] If a profession is defined in terms of the possession of specialized knowledge and the fulfillment of some society need, the medical profession is specified by its commitment to the health needs of society. This commitment is formalized by each member professing the Medical Oath. [118] In light of these goals, the medical virtues are character traits that enable the physician to achieve the goals of medicine with excellence.[119]

In response to Veatch's critique of pure virtues, the authors propose a combined approach that aims to connect virtues and principles in a coherent framework. Though virtues alone are not sufficient for medical ethics, they believe that virtues are indispensable, because the character of the physician (and of the patient) is always at the heart of medical choice and action.[120] In their view, virtue-based ethics could – and ought to – be joined to principle-based ethics so that the limitations of each approach

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[116] Ibid., 52.

[117] Edmund D. Pellegrino, "Professionalism, Profession and the Virtues of the Good Physician" paper presented at the Issues in Medical Ethics 2000 Conference at the Mount Sinai School of Medicine, New York, NY on November 3, 2000. Printed in *The Mount Sinai Journal of Medicine* Vol. 69, No. 6, Nov 2002, 378-384.

[118] Ibid, 378-379.

[119] Ibid, 381.

[120] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 19.

could be overcome.[121] The two authors believe that virtues and principles could be linked by the exercise of prudence,

> The virtue of prudence, that is, practical wisdom, enables us to arrive at that right and good ordering of principles and concrete facts in particular cases… The prudent physician or patient is the one who can order habitually fact and principle most sensitively and correctly to each other and act appropriately to achieve the good for the patient – and, parenthetically, for the physician at work.[122]

Appealing to the works of Aquinas, the authors argue that not only can virtues and principles coexist, but they can also complement each other. Though they propose a combined approach, their emphasis remains on the virtues throughout. This emphasis is in line with Aristotelian-Thomistic virtue ethics. Aquinas himself in the *Summa Theologiae* assigns primacy of place to the cultivation of virtues and personal character, and a secondary role to law.[123] With Etienne Gilson, Pellegrino and Thomasma hold that virtue ethics is essential because it links abstract principles and obligations to specific circumstances of life through the virtue of prudence.[124]

If the ends of medicine provide the context for physician virtues, Pellegrino and Thomasma believe that the biomedical principles respect for autonomy, beneficence, nonmaleficence and justice can also be interpreted in this new, teleological context.[125] If the end of medicine is health, the good of the patient ought to be the goal of the medical encounter. In this context, beneficence becomes the nature of medical acts; respect for

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[121] Ibid., 19-20.

[122] Ibid., 23.

[123] Stephen Pope, *The Ethics of Aquinas* (Washington, D.C.: Georgetown University Press, 2002), 49.

[124] Etienne Gilson, *Moral Values and the Moral Life: The Ethical Theory of St Thomas Aquinas* (Hamden, CT: Shoe String Press, 1961).

[125] Edmund Pellegrino & David C. Thomasma, *The Virtues in Medical Practice*, 52.

autonomy serves the good of the patient which necessarily includes his values and aspirations; maleficence is the violation of the healing end of the relationship; and justice demands fidelity in response to patient trust.[126] In connection with these, Pellegrino and Thomasma also list promise keeping, protection of patient confidentiality, and truth telling among the requirements of the physician-patient relationship. They propose eight virtues that are important in medicine: fidelity to trust, compassion, phronesis, justice, fortitude, temperance, integrity, and self-effacement.[127]

1.3.2.1. Pellegrino and Thomasma: The Medical Virtues

Similar to Drane, Pellegrino and Thomasma discuss the medical virtues in the context of the physician-patient relationship. The first virtue they list is *fidelity to trust*, emphasizing the fiduciary nature of the clinical relationship. Patients must be able to trust physicians to whom they turn in times of need and distress. Illness is a state of vulnerability and dependence that forces persons to seek assistance from professionals who have specialized knowledge and skill. It is the physician's virtue of fidelity that engenders this trust in the patient. The authors list five elements of trust (1) the confidence in the fidelity of the other; (2) the promise explicitly or implicitly made by the trustee to act well on behalf of the interests of the trusting person; (3) a certain degree of discretionary latitude is permitted; (4) the congruence of understanding between the two persons in regard to these first three elements; and (5) an underlying act of faith in the

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[126] Ibid, 53.

[127] Ibid., 52-53. Pellegrino in a subsequent article lists fidelity to trust, benevolence, intellectual honesty, courage, compassion and truthfulness as the essential virtues in medicine. See "Professionalism, Profession and the Virtues of the Good Physician," 381.

benevolence and good character of the trustee.[128] While a general trust in the system is sufficient to bring the patient to consultation with a physician, a more personal trust in the physician is essential because the patient expects to expose more private domains of mind, of body and of relationships to the physician. The authors write,

> Ultimately, we must place our trust in the person of the physician. We want someone who knows about us, treats us non-judgmentally, and is concerned with our welfare. We want someone who will use the discretionary latitude our care requires with circumspection … to serve the healing purposes for which we have given our trust in the first place. We must trust also that our vulnerability will not be exploited for power, profit, prestige, or pleasure.[129]

Because of the physician's specialized knowledge and skill, and because illness is a time of vulnerability, inequality is a given in a medical relationship. Trust sometimes comes down to the choice between our own judgment and that of someone whom we believe to have greater knowledge and objectivity, as well as a commitment to our well-being.[130] Trust in the professional relationship, they argue, is indispensable, because without trust, the relationship cannot attain its end. They contend that "If there is any meaning to professional ethics, it must revolve around the obligation of fidelity to trust."[131]

Pellegrino and Thomasma believe that patients should not entrust physicians with the total responsibility to determine the good for them, nor should physicians assume such duty. Patients should be supported by their physicians to make their own decisions. However, because the physician will inevitably be involved in important decisions the patient is to make, the physician should become familiar with the patient and what

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[128] Ibid, 67.

[129] Ibid, 68.

[130] Ibid, 68-69.

[131] Ibid, 75.

constitutes the patient's best interests. The medical good ought to be placed within a larger context of the patient's values, goals and commitments. The physician also helps the patient to anticipate critical decisions in regard to serious illness and end-of-life care, and does it with sensitivity at an appropriate time. The virtue of fidelity to trust prevents manipulation, coercion or deception in the explanation of medical options. An ethic of trust requires character formation and professionalization through practice. Professionals cannot expect to be trusted simply because of their role. Trust must be earned by the professional and built up within the healing relationship.

The authors believe that an ethic of trust does not make the physician's fiduciary role absolute. The physician should welcome the patient's choice to seek a second opinion. When the patient's values are sharply at odds with those of the physician, the physician can decline to enter the relationship or withdraw from it graciously.[132] Precisely because trust is essential in a medical relationship, effective regulation of the profession by ongoing training and accreditation, while quality controls and liability laws are of vital importance.

The second virtue the authors propose is compassion, which they define as "a habitual disposition, to act in a certain way… that facilitates and enriches the *telos* or purpose of whatever human acts we perform."[133] In medical practice, compassion is "the character trait that shapes the cognitive aspect of healing to fit the unique predicament of *this* patient."[134] The good physician suffers with the patient, taking upon herself or

[132] Ibid, 76.

[133] Ibid, 79.

[134] Ibid.

himself something of the patient's pain. Compassion is embedded within a personal relationship with a particular physician or nurse. While compassion is indispensable to attaining the end of medicine, there is also a downside to over identifying with the patient's suffering. The physician who suffers with the patient may unconsciously impose her or his values on the patient. For this reason, compassion must be balanced with other virtues: competence and prudence. Compassion also has a particular connection with friendship. Through the virtue of compassion, the person is able to share another's experience of illness and assist as a friend who helps the other through the experiences of illness, hospitalization, of pain and grief. A physician acts similarly and co-suffers as a friend. This co-suffering establishes a bond between physician and patient which facilitates effective medical interventions. The authors maintain that compassion and competence must go hand in hand.[135]

The authors also advocate the application of four cardinal virtues in Aristotelian-Thomistic tradition: prudence, justice, fortitude, and temperance to medical practice. They explain prudence in Aristotle's usage as the capacity "to discern what moral choice or course of action is most conducive to the good of the agent."[136] It is the intellectual virtue that disposes the agent to truth for the sake of action. For this reason, prudence is the link between the intellectual virtues – which dispose to truth – and those which dispose to good character. It is the capacity to discern, within a given set of circumstances, the good to be achieved and how to achieve it. Prudence is the link between the cognition of the good and the disposition to seek it through particular acts,

[135] Ibid, 81-83.

[136] Ibid, 84.

and through the cultivation of moral virtues.[137] If the *end* of medicine is the health of the individual and society, the prudent physician chooses the course of action that is *right* for the patient in both the medical sense and the moral sense. Medical considerations involve knowledge of the patient's condition, and judgment regarding the therapeutic options available. Moral discernment involves situating the medical good among other parameters that constitute patient interests: personal values, lifestyle, beliefs and commitments.[138] Prudence also helps moderate other virtues, such as compassion and honesty in clinical practice.[139]

The virtue of justice is understood by the authors in relation to distributive justice, to render to others what is due to them. Without going into the complex theories of justice, they explain justice as "a requirement for a peaceable society and the protection of legitimate self-interest."[140] As such, it is a claim the individual has on the community, while compliance with it is the duty of the individual living in that community. Justice informed by love is expressed in special concern for the poor, the oppressed, and those who suffer. From this perspective, the lack of access to adequate health care for a significant percentage of U.S. residents is a justice issue. Furthermore, the gate keeping role frequently forces health professionals to consider patient interests against the interests of the institutions or the HMO. Justice considerations are also increasingly significant in the care of the elderly. The point of emphasis for the authors on this virtue is how the healing relationship is to be construed and constrained. Neither the

[137] Ibid, 85.

[138] Ibid, 86.

[139] Ibid, 87-89.

[140] Ibid, 94.

contractual model nor a paternalistic one is sufficient. For the authors, the healing relationship must be motivated by love and justice, thus a high degree of self-effacement is required.[141]

Fortitude is the moral virtue that enables the physician to minister to patients in warfare or civil emergency situations, in areas of epidemics, in treating persons with a virulent disease such as HIV/AIDS. In regard to medical practice, the authors explain that fortitude is "the virtue that renders an individual capable of acting on principle in the face of potential harmful consequences without either retreating too soon from that principle or remaining steadfast to the point of absurdity."[142] Moreover, within the context of increasing government and third-party regulations which aim at reducing costs, sometimes to the detriment of the poor and the elderly, fortitude is especially relevant if physicians are to speak out against inequities or on behalf of patients where the need arises. Fortitude in medicine is the moral strength "to resist the temptation to diminish the patient's good" through fear, or through social and bureaucratic pressure.[143]

Temperance in the physician is explained in regard to the use of medical knowledge and power, which may give rise to the temptation to "play God." At the other extreme is a careless disregard for the patient's needs, the patient's values or quality of life.[144] The authors discuss this virtue in reference to the use of medical technologies, such as dialysis, cardiopulmonary resuscitation, intensive care facilities, genetic

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[141] Ibid, 100-105.

[142] Ibid, 111.

[143] Ibid, 114.

[144] Ibid, 120.

manipulation, and end-of-life care. They define temperance in medicine as "the constant disposition of physicians toward responsible use of power for the good of their patients," avoiding both overuse and underuse of available medical resources in patient management.[145]

The seventh virtue the authors discuss is integrity. According to the authors, a person of integrity is one who "integrates all of the virtues," is worthy of trust, and able to judge a right course of action with due attention to the principles, norms and virtues relevant to each situation.[146] The virtue of integrity in both the physician and the patient is necessary to bring about the healing aim of the physician-patient relationship. The authors argue that the concept of integrity is more fundamental than the concept of autonomy which is widely promoted in bioethical discourse. They distinguish the two senses of integrity in medical ethics: the integrity of the person, and being a person of integrity. The first sense is more descriptive, referring to the right ordering of the parts in relation to the whole for the healthy functioning of the organism.[147] The integrity of the person refers not only to bodily and mental health but also to the balanced relationship with others in society. A serious illness thus represents a form of disintegration of the person. The authors also discuss respect for autonomy under the rubric of personal integrity. There are values and beliefs that a person esteems and identifies with. The moral integrity of the person consists in making choices in accordance with these deeply held values and aspirations. Yet, at the time of illness, these values may be in conflict

[145] Ibid, 122.

[146] Ibid, 127.

[147] Ibid, 129.

with those of the physician, family members, or society. They reason that, because healing means to make whole again, the restoration of the integrity of the person, in its fullest sense, is the aim of genuinely holistic medicine.[148] The second sense is more prescriptive, referring to the moral integrity of the physician. In order to preserve the personal integrity of the patient, the physician ought to be a person of integrity. In their explanation of this virtue, the authors emphasize again the essential role of trust in the healing relationship. The virtue of integrity refers to the fidelity to this relationship, the sensitivity to patient needs and care in the use of the Aesculpaean power.[149] In the field of medical research, the authors use the word integrity to refer to fairness in designing and implementing the research trials, respect in obtaining informed consent, and honesty in reporting results.[150]

The final, also the most counter-cultural of medical virtues, is self-effacement. The authors discuss this virtue as a response to what they describe as widespread "narcissism of our age," and the deficiencies in professional ethics. They believe that, within the contemporary climate of moral malaise among the professionals, self-effacement, or altruism, is key to the revival of the concept of the profession, and of professional ethics. As guardians of patient welfare, physicians at times ought to stand up against what might be considered common practice. For instance, physicians should not refuse to turn away the patient who cannot pay, to discharge the patient too early, to

[148] Ibid, 129-130.

[149] Ibid, 132.

[150] Ibid, 133-134.

act as society's fiscal agent, or to put profits before patient care.[151] Furthermore, the medical profession as a moral community has the obligation to advocate for those in need of healing and to protect them against legislation and policies that may harm them.[152] To enforce itself as a moral community, a profession must take responsibility for its member's conduct by monitoring, discipline, or removal when necessary. Together with other professions, health professionals should use their moral power to bring about social change in favor of those they serve.[153]

1.3.2.2. Pellegrino and Thomasma on Medical Virtues: An Evaluation

Pellegrino and Thomasma propose a normative ethic based on the concept of the community, with its tradition and practices as the context of the virtues. Their combined approach, that aims to integrate the medical virtues with the principles in an overall framework, is in line with the Thomistic tradition, though the exact relationship between virtues and principles is not adequately explained. The authors identify the medical profession as a community with its own practice, which is medicine. This community has its own ends, which are related to the ends of medicine. They define the ultimate end of medicine as the service of health, and the proximate end as to heal and care for the patient.[154]

Pellegrino and Thomasma acknowledge the intellectual indebtedness to Alasdair

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[151] Ibid, 157.

[152] Ibid.

[153] In their subsequent work, the authors also discuss the Christian virtues faith, hope and charity in relation to medical practice. Edmund D. Pellegrino & David C. Thomasma, *The Christian Virtues in Medical Practice,* (Washington, D.C.: Georgetown University Press, 1996).

[154] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 52.

MacIntyre for the concepts of community, tradition, and practice which feature highly in their virtue theory. However, there is a significant difference between MacIntyre's view of the communal context of the virtues and the view presented by the two authors in *The Virtues in Medical Practice.*[155] MacIntyre defends the view that moral agents belong to certain communities which have their particular narratives and practices. The person learns how to act by understanding the practices of the communities, and the roles and norms which are assumed within these practices. As an individual's act is made intelligible by the individual's narrative context, the practices and norms of a community are made intelligible by its collective narratives.[156] MacIntyre emphasizes the importance of the *found* community with its stories and practices, of which the agent is part. The community's narrative is oriented toward a *telos*, which provides a normative bearing on the community's practices and actions. For MacIntyre, the normative good of the community is identified with Aristotle's *telos* or the end of human life. It is also this *telos* which gives the context and substance to the virtues.[157] This *telos* also tells us where we are in relation to it, and whether our actions take us closer or further away from it. Further, MacIntyre grounds a moral act in the context of the collective narratives of which the individual narrative is part, and the practices of the community. The good for a particular individual is the good for someone who is in the individual's roles.[158] The individual is identified within the roles which are inherited. In MacIntyre's words, "As

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[155] See also Edmund D. Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions" in Kennedy Institute of Ethics Journal, (1995), Vol. 5, No. 3, pp. 253-277. In this article, Pellegrino also acknowledges MacIntyre's innovative insights about the communal context of the virtues, and seeks to adapt these insights into medical practice.

[156] Alasdair MacIntyre, *After Virtue* (Notre Dame, Ind.: University of Notre Dame Press, 1981/2007), 216.

[157] Ibid, 219.

[158] Ibid, 220.

such, I inherit from the past of my family, my city, my tribe, my nation, a variety of debts, inheritances, rightful expectations and obligations. These constitute the given of my life, my moral starting point."[159] To MacIntyre, the individual agent is part of a collective history, and a bearer of the tradition.[160]

Note that MacIntyre's concepts of *community* and *practice* refer to concrete historical realities, rather than abstract ideas that transcend time and cultures. Applying this to medicine, if the medical profession is a *community* in MacIntyre's use of that word, it would not be the medical profession in general, but a particular community of medical practitioners, such as the American Medical Association, that exists in time, with its own history, tradition and practices. Take the case of the American Medical Association (AMA), it is a community with a tradition that began in Greco-Roman medicine, passed down and developed through European medical discipline, and takes its current shape in the contemporary North American context. Similarly, MacIntyre's concept of the practice does not correspond to medical practice in the abstract, but to the concrete historical *practices*, which members of a particular medical community engage in. For instance, medical consultation is a practice more in line with MacIntyre's view. Through interaction with the patient, the physician establishes a history of illness, performs a physical examination, and proposes a plan of action, which might involve some diagnostic investigations and/or therapy, or a referral for specialist assessment. It is the practice by which the physician's specialized skills and knowledge are used to benefit the patient, and the physician by doing so achieves the ends of medicine. Medical

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[159] Ibid.

[160] Ibid., 221.

consultation is also the context of the virtues. Within this practice, there are other practices, such as history taking, counseling patients, physical examinations, each of which involves a number of activities, and all practices can be perfected by the virtues. Needless to say, these practices also bear the marks of the community's tradition, which in the case of the AMA means the Euro-American medical tradition.

Pellegrino and Thomasma on the other hand, present somewhat abstract concepts of the medical profession as a community, and medicine as its practice. In comparison to MacIntyre's largely *descriptive* understanding of community, their defense of the concept of community has a *normative* significance at two levels. First, they argue that the medical profession ought to be a moral community, despite current attempts to redefine it. At this level, community is defined by the bond of a common practice and the shared goals which provide context for the virtues. At the second level, the authors argue that because of the distinctiveness of medicine, and because of its own tradition, the medical profession as a community ought to aspire to higher moral standards and cultivate certain virtues. Throughout the book, the authors refer to medicine and the medical profession as general philosophical ideas rather than concrete, historical realities, and their assertions about medicine and the profession are meant to have universal significance for all medical practitioners. However, though they refer to "the medical community" in general, their appeals to tradition refer exclusively to the Euro-American medical tradition and its roots in Greco-Roman medicine. Their descriptions of the medical virtues also reflect strongly the questions and emphases of the North American context. Without specifying explicitly *which* medical community they are referring to, it is clear that they have in mind a particular medical community with its own concerns and needs

to which they respond. For this reason, the virtues that the authors propose are linked to the particular communal context within which they are conceived, and are relevant only for that community. It means that, in proposing a community-based virtue ethic for the medical profession, Pellegrino and Thomasma must deal with the relativism in MacIntyre's view of the community and its practices.

Pellegrino in his later article[161] explicitly distances himself from MacIntyre's view in order to promote the concept of the "internal morality" of medicine, which I believe is already implicit in *The Virtues in Medical Practice*. In this article, Pellegrino aims to strip away the contingencies of history and cultures, in order to arrive at the universal human good which he argues can provide the basis of medicine's internal morality. He writes,

> Many valuable facets of MacIntyre's notion of a profession as a practice are congruent with the idea of an internal morality. MacIntyre, however, places much emphasis on a societal construction of the profession and its goods and virtues. In my view, these are external to clinical medicine. Medicine exists because being ill and being healed are universal human experiences, not because society has created medicine as a practice. Rather than a social construct, the nature of medicine, its internal goods and virtues, are defined by the ends of medicine itself, and therefore, ontologically internal from the outset.[162]

Pellegrino's proposed internal morality goes beyond the community-based approach, because its authority is independent of whether or not physicians accept it. As he sees it, this authority "arises from an objective order of morality that transcends the self-defined goals of a profession."[163] Internal morality is not closed to insights from history, literature or the sciences, for it draws on these disciplines to the extent that they

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[161] Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions" in *Journal of Medicine and Philosophy* (2001), Vol. 26, No. 6, 559-579.

[162] Ibid, 563.

[163] Ibid, 564.

illuminate the universal phenomena of being ill and being healed, and of professing to heal.[164] Drawing upon the works of Aristotle and Aquinas, Pellegrino defines the goals of medicine in terms of the human good. He explains the human good under four components: the medical good, the patient's perception of the good, the good for humans, and the spiritual good.[165] In his view, there is a hierarchical order to the goods: the spiritual good takes priority, then the good for humans, the person's perceived good, then at the lowest level the technical good specific to the profession.[166]

Most remarkable is Pellegrino's claim that the internal morality of medicine has universal significance. I maintain that this claim is valid only to the extent that Pellegrino adheres to a "thin" description of the human good, without expanding it to include a "thick" description of values and norms. For instance, self-determination is a moral norm which has its own historico-cultural context, and the "thick" formulation of this norm may not apply readily to other cultural contexts.[167] The "thin" version would be akin to the Aristotelian nature-based framework that Oakley and Cocking propose. Furthermore, Pellegrino's four components of the human good seem to converge with what Drane describes as universal patient needs.

1.3.3. JAMES F. KEENAN AND THE GROUNDING OF THE VIRTUE OF JUSTICE

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[164] Ibid, 565.

[165] Ibid, 569-571.

[166] Ibid, 575.

[167] My use of "thin" and "thick" refers to Michael Walzer's usage in *Thick and Thin: Moral Argument at Home and Abroad* (Notre Dame, IN: University of Notre Dame Press, 1994).

A significant question for any virtue-based medical ethic is how *justice* is grounded within its proposed framework. Note that Drane lists justice as a medical virtue, so do Pellegrino and Thomasma. In light of recent works that have underscored the social determinants of health, the virtue of justice ought to be what prompts the moral physician to confront unjust structures and practices that predispose persons to poverty and ill health.[168] Drane asserts that the virtue of justice is based on the social dimension of the physician-patient relationship, but ultimately rooted in the nature of the human person. Drane does not explain this point well. If his theoretical grounding of the virtues is the clinical relationship, it is not clear how physicians are obliged by justice to reach out and attend to the welfare of persons outside of that relationship. More than any other virtues, justice ought to be grounded in something more fundamental than the clinical relationship. The virtues proposed by Pellegrino and Thomasma actually reflect a diverse range of moral claims associated with different types of relationships and moral commitments. For instance, the authors see fidelity and compassion as virtues associated with the physician-patient relationship; while the virtue of *justice* is discussed in the broader context of the whole society and international communities. Their theory does not address the complexity of these moral claims. In this regard, Keenan's proposal of the theoretical grounding of the virtues is helpful. For Keenan, the cardinal virtues are grounded in human nature, which is essentially relational.[169] In his view, our identity is

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[168] See for instance Paul Farmer, *Pathologies of Power* (Berkeley/Los Angeles: University of California Press, 2005); James F. Keenan with Jon Fuller, Lisa Sowle Cahill and Kevin Kelly (ed), *Catholic Ethicists on HIV/AIDS Prevention*, (New York/ London: Continuum, 2005).

[169] James F. Keenan, "What Does Virtue Ethics Bring to Genetics" in Lisa Sowle Cahill (ed), *Genetics, Theology, And Ethics : An Interdisciplinary Conversation*, (New York: Crossroad Publications, 2005), 97-110.

relational in three ways: generally, specifically, and uniquely. For this reason, he proposes three cardinal virtues: justice, fidelity, and self-care that correspond to the different dimensions of human nature. He explains,

> as a relational being in general, we are called to justice; as a relational being specifically, we are called to fidelity; as a relational being uniquely, we are called to self-care… The fourth cardinal virtue is prudence, which determines what constitutes the just, faithful, and self-caring way of life. [170]

This is a useful theoretical structure for the medical virtues, because it reflects the plurality of moral claims associated with the multitude of communities to which each of us belongs. A physician is called to *fidelity* to patients, as well as fidelity and courtesy to other health professionals. In addition, as a member of the wider society, the physician is called to *justice* which can involve action on behalf of the poor and disenfranchised. The virtue of *self-care* helps balance the excesses to which the health professional is frequently exposed by institutional demands and patient needs. *Prudence* is the guiding principle for moral discernment amidst these conflicting claims. Keenan's nature-based virtue claims are also compatible with the Aristotelian *eudaimonistic* view of professional ethics proposed by Oakley and Cocking, insofar as they fulfill two criteria (i) these virtues enable physicians to perform their medical functions well, thus contribute ultimately to the human good of *patients*; and (ii) these virtues are part of the web of intrinsic goods that constitutes the human good of *physicians*. I argue that Keenan's four virtues fulfill both criteria. First, fidelity, justice, self-care and prudence are virtues that

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[170] Ibid, 102. Also James F. Keenan, "Proposing Cardinal Virtues" in *Theological Studies*, Dec. 1995, Vol.56(4), 709-730; "Virtue and Identity" in Hermann Haring, Maureen Junder-Kenny, and Dietmar Mieth (eds), *Creating Identity: Biographical, Moral, Religious*, (Concilium 2000/2; London: SCM Press, 2000), 69-77; "Virtue Ethics and Sexual Ethics," in *Louvain Studies* 30 (2005), 183-203; "Can We Talk? Theological Ethics and Sexuality," in *Theological Studies* Mar. 2007, Vol. 68(1), 113-132.

help physicians perform their professional role well and contribute to the human good of patients. As Keenan explains, the four virtues are simply "skeleton" structures, in order to apply them to biomedical ethics, the virtues of *fidelity* and *justice* need to be connected to the clinical relationship, and explained within the proper socio-political context of health care in a particular location.[171] Second, besides helping physicians excel in their professional role, the four virtues are also integral to the human good of physicians. In short, Keenan's four virtues can be considered as both professional virtues and human virtues, for they serve both the *end* of medicine, and the human good of the physicians who practice them. However, Keenan's four virtues are not specific to medical practice. In his discussion on sexual ethics, Keenan suggests that each of the cardinal virtues ought to be informed by the virtue of mercy.[172] This is also relevant for medical ethics, because mercy is a defining virtue of early Christianity and of early Christian health ethics, when Christians gave of their resources, sometimes putting their own lives at risk, to help poor patients in crowded Greco-Roman cities.[173]

1.4. THE RELATIONSHIP BETWEEN VIRTUES AND PRINCIPLES

[171] Keenan, "What Does Virtue Ethics Bring to Genetics," 97-110.

[172] Keenan, "Can We Talk? Theological Ethics and Sexuality," 122-123.

[173] Keenan, *The Works of Mercy,* 4-5. See also Darrel W. Amundsen & Gary B. Ferngren, "Virtue and Medicine from Early Christianity through the Sixteenth Century" in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 49-59. In Chapter Three I shall demonstrate that mercy is a major virtue in Luke's depiction of Jesus' healings. Cf. the Hippocratic tradition has beneficence as the foundation of medicine.

A crucial question for virtue-based medical ethics is how virtues are related to principles. Within the post-Nuremberg Euro-American context, it is generally agreed that certain moral norms and principles are indispensable in human research and health care. As discussed previously, Veatch believes that virtue ethics ought to have at most an augmentative role in relation to principles. In his view, virtues are derived preferably from principles, and virtues are useful only to the extent that they help persons perform right acts as prescribed by principles. I argue that this view is inadequate, because it disregards the virtues and vices of the agent who performs those '*right acts*.' In the realm of health care, it is the question of physician character, and the virtues or vices which might be acquired by following the principles.

Drane adopts a "middle position" and maintains that virtues cannot be detached from principles and norms. Interestingly, while Drane's virtue theory is partly in response to Veatch's critique of pure virtue, his proposed medical virtues are strongly in parallel with the Georgetown bioethical principles. Drane's explanation of the virtue of benevolence corresponds with the principles of beneficence and non-maleficence; the virtue of respect with the principle of respect for autonomy; and the virtue of justice with the principle of justice. However, it would be hasty to conclude that Drane follows Veatch's suggestion and derives virtues from principles. From a Thomistic perspective, precepts are at the service of the virtues, but not the reverse. Drane's view seems well aligned with the Aristotelian-Thomistic tradition as he asserts that the virtue of justice is cultivated by the practice of just acts, and just doctors are good physicians as well as good human beings.

Pellegrino and Thomasma on the other hand propose a combined approach, which aims to account for both principles and virtues. Prudence assists in the discernment of right actions in light of principles and circumstances. Though these assertions are in line with the Thomistic tradition, the precise relationship between the virtues and principles is not adequately discussed. Another feature of the two authors is the attempt to *do justice* to both principles and virtues. They include four Georgetown bioethical principles, four cardinal virtues of the Aristotelian-Thomistic tradition, and propose some other virtues which they believe to be important for contemporary medical practice.

From a Thomistic viewpoint, as Daly emphasizes, the moral precepts function as a guide for the cultivation of virtues.[174] While Veatch's emphasis is on the principles, Aquinas presents a teleological framework in which moral norms are determined in the context of the natural law and the acquired virtues under the guidance of prudence. To explain Aquinas' view of the relationship between virtues and norms, Daly highlights the distinction made between primary secondary precepts in the *Summa Theologiae*. Primary precepts are general, self-evident, and universally binding across cultures and time.[175] Secondary precepts (or norms) are shaped by history and cultures. Secondary precepts are universal in meaning, but not universal in application, because their application is dependent upon the circumstances of a situation. Further, because secondary precepts are teleological in nature, they could be applied insofar as they promote their intended end

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[174] Daniel Daly, "The Relationship Of Virtues And Norms In The Summa Theologiae" in *The Heythrop Journal* (2010), No. 51, 2, p. 214–229.

[175] Ibid, 216-217. Cf. also Jean Porter, "A Tradition of Civility: The Natural Law as Tradition of Moral Inquiry" in *Scottish Journal of Theology* 56(1): (2003), 27-48.

within the circumstances of the case.[176] For instance, the secondary precept of preserving justice is universal in terms of truth, but its application varies with the circumstances of each case. For Aquinas, right acts are defined in terms of fittingness, both internally in relation to the agent and externally in relation to the overall good of the agent and his community. [177] In light of the contingent factors surrounding the human act, as well as the teleological nature of moral norms, the application of moral norms to concrete acts requires the virtue of prudence.[178] Prudence helps discern the correct means to a good end. Daly stresses that Aquinas did not provide a set of predetermined secondary precepts to guide action, but rather a robust notion of the moral virtues and the exercise of prudence, for these are crucial in the discernment of what is fitting in concrete circumstances. With secondary precepts as a guide, the person with practical wisdom can grasp the situation, the precepts, and what is required of the agent in the concrete situation.

If secondary precepts are action guides, and prudence helps discern the fitting means to good ends, then it is the moral virtues which provide the ends to be obtained. Within this teleological context, moral norms play a vital role in the person's movement towards the goal of human life. The human *telos* for Aquinas is friendship with God and with neighbors, and it is achieved only through a life of virtue. Norms are valued because they help form the agent's character. They help guide the agent into the life of virtue. In other words, moral norms educate the agent in the virtues through moral

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[176] Daly, "The Relationship Of Virtues And Norms In The Summa Theologiae," 217.

[177] Ibid, 218.

[178] Ibid, 220-221.

acts.[179] Moral norms help cultivate a virtuous character by prescribing 'acts of virtue' for the agent. When the agent does these acts habitually, with full consent, and within the *ordo rationis*, virtues are formed. Norms are thus instruments for the moral development of persons through the cultivation of virtues.[180] This is in line with Keenan's view that, within the Thomistic structure, norms are generated in the pursuit of virtues.[181] Virtue ethics not only promote virtues, but also norms and principles that we need for the moral life.[182] For Aquinas, norms are necessary, because "virtues without norms are blind, especially for the young and the vicious."[183] Apprentices in moral life lack the internal sense of the good, and require concrete guidance in the good through norms. For Aquinas, secondary precepts are not derived deductively from primary precepts, but they are inductively derived through experience and reflection on the ends, under the guidance of prudence.[184]

Daly summarizes the relationship between norms and virtues in two interrelated points. First, norms are teleological. They have to be applied in the context of the virtues. Norms are action guides that cannot be detached from the kind of life that ought to be lived. In light of this end, norms have an educational purpose in the formation of moral character. Further, the right application of norms requires a virtuous agent who is

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[179] Ibid, 223.

[180] Ibid.

[181] Keenan, "Virtues, Principles and a Consistent Ethics of Life" in Thomas Nain (ed), *The Consistent Ethic of Life: Assessing Its Reception and Relevance*, (Maryknoll, NY: Orbis Books, 2008), 50-54.

[182] Cf. also Yiu Sing Luke Chan's doctoral dissertation, "Why Scripture Scholars and Theological Ethicists Need One Another: Exegeting and Interpreting the Beatitudes as a Scripted Script for Ethical Living" Boston College, Theology Department, December 2010, 217-219.

[183] Daly, "The Relationship Of Virtues And Norms In The Summa Theologiae," 224.

[184] Ibid, 225.

properly directed to the ends of life and has the capacity to discern the fitting means to those ends.[185] Contrary to Veatch's view, Aquinas understands the moral life, which is the life of virtue, as dynamic, internal and far richer than rule-following. Principles and norms help the agent acquire the interior movements towards the good, and help cultivate the right habits and dispositions to act well. But principles alone are not enough to cause a right and good action.[186] Aquinas also permits dispensation from the requirements of norms, when a norm violates a given virtue and the good promoted through that virtue. The mature moral agent understands the norm and the ends or goods which it helps to promote. Norms provide provisional guidance, though that guidance is crucial for the young and the "vicious," who lack the internal resources to discern and do the good.[187]

Second, the right application of norms requires prudence. The criterion of *convenientia* requires that moral reasoning be done with due attention to the relevant contingent factors. Aquinas' own example of this is whether or not to return the sword to a disturbed madman in order to fulfill the moral precept that prescribes giving back to persons what belongs to them. For Aquinas then, a deductive or deontological application of norms would be inadequate.[188] Further, with the acquisition of virtues, norms become less important, because the meaning of the norm has been internalized in a person of virtue. In this case, the mature agent knows *how* the norm is intended to guide, and understands the primacy of the spirit of the norm, not the letter. In light of this,

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[185] Ibid.

[186] Ibid, 225.

[187] Ibid, 226-227.

[188] Ibid, 226.

Drane's six virtues are not 'derived' from bioethical principles, but they are character traits that the principles and norms help to cultivate in the physician. It is therefore logically defensible to propose medical virtues that are related to moral norms in the context of the goals of medicine.

1.5. THE UNIVERSALITY VERSUS CULTURAL SPECIFICITY OF THE VIRTUES

Earlier, I have discussed Veatch's point about the feasibility of proposing a list of virtues acceptable to all in a pluralistic society. In response, Drane suggests that physician virtues may be grounded in patient needs, which he believes to be common to all human beings. The six areas of patient needs, which Drane identifies, do have universal relevance and the six virtues resonate somewhat across time and cultures. However, as soon as Drane describes these virtues in detail, they take on the concerns and emphases of his own time and the North American socio-cultural context. The point at hand concerning the universality of the virtues is related to Aquinas' understanding of the primary and secondary precepts of the natural law. For Aquinas, primary precepts are universally binding for all across time and cultures, but they are general and self-evident. In other words, they are *thin* expressions of what is normative for human life. On the other hand, secondary precepts are developed within history and culture. They are *thick* expressions of the normative ideals specific to particular socio-historical contexts. For this reason, secondary precepts do not apply universally. In a similar way, virtues are thought to be universally relevant insofar as they communicate a minimal expression of the human ideal without taking on *thick* expressions that are specific to the historical and

cultural context. Based on Aristotle, Martha Nussbaum lists eleven spheres of universal human activity, and the corresponding virtues that can perfect them.[189] Based on these spheres of human activity, Nussbaum promotes an ethic grounded in what is essentially human. To the extent that Nussbaum's description of the virtues remains minimal, her ethic can claim universal relevance and provide a basis for dialogue across cultures. In light of this, Keenan rightly suggests that the task of proposing universal virtues is possible as long as those virtues simply provide a 'skeleton' of the normative human life and the basic goals of human action.[190] Keenan proposes four cardinal virtues that he *thinly* describes, so as to avoid introducing concerns and emphases from his particular culturo-historical context.[191]

Grace Y. Kao in her insightful book defends the claim that human rights are universally valid, and discusses the various approaches for grounding these universal claims. In her view, human rights provide universal moral standards which help hold states more accountable for the way they treat their own citizens, and at times serve as an evaluative tool to measure the legitimacy of domestic regimes. [192] Kao discusses two types of approach to the grounding of human rights, the *maximalist* and the *minimalist*. The *maximalist* approach is based on the claim that human rights can be adequately defended only on religious grounds. Therefore, human rights claims have to be grounded

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[189] Martha Nussbaum, "Non-Relative Virtues" in *Midwest Studies in Philosophy* 13.

[190] Keenan, *Proposing Cardinal Virtues*, 714.

[191] John H. Evans argues that the success of principlism in North America is due to the appeal of these four simple principles which function as "commensurable scales" in decision making. Somewhat similar to the universal virtues, the principles are thin expressions of the normative requirements in bioethics. See "A Sociological Account of the Growth of Principlism" in *The Hastings Center Report,* Sep/Oct 2000, 31-38.

[192] Grace Y. Kao, *Grounding Human Rights in a Pluralist World*, (Washington D.C.: Georgetown University Press, 2011).

in the thick account of the normative human life informed by religious insights and commitments. This approach is exemplified in The Cairo Declaration on Human Rights in Islam (1990), the papal encyclical *Pacem in Terris* (1963), the Parliament of the World's Religious Declaration toward a Global Ethic (1993), and the works of Michael Perry, Hans Kung, Max Stackhouse, and Nicholas Wolterstorff. The *minimalist* approach seeks to strip away the cultural specificities so as to come to the common humanity that is shared by all across cultures. Among minimalists, Kao lists John Rawls who proposes the enforcement-centered approach, Jacques Maritain and the consensus-based approach, and Martha Nussbaum with the capability-based approach. Kao suggests that each approach has its own weaknesses and strengths, and the best way to ground human rights is through negotiating between the *maximalist* and the *minimalist* approaches, drawing critically from each one, while avoiding the extremes of either one.[193]

The affirmation of human rights clearly challenges certain ethical viewpoints, including cultural relativism, as well as the post-colonial criticism of ethical universalism in favor of local traditions. Maria Christina Astorga names the Bangkok Declaration of 1993 as an example of East Asia's reaction against demands made by Western states for homogeneous compliance with the universal normative claims of human rights.[194] While ministers of the participating Asian states reaffirmed the universality of human rights, they placed greater emphasis on economic, social and cultural rights over civil and political rights. They also stressed the principles of sovereignty and non-interference,

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[193] Ibid, 1-10.

[194] Maria Christina Astorga, "Human Rights from an Asian Perspective" in *Human Nature and Natural Law* edited by Lisa Sowle Cahill, Hille Haker, and Eloi Messi Metogo (London : SCM Press, 2010), 92. .

and insisted that the right to economic development is among fundamental human rights.[195] Astorga sees the "Asian values" argument as an attempt to present a counter-model to the Western way of life. This supposedly Asian approach to human rights would defend the model of development that involves trade-offs between civil and political rights on the one hand, and social stability and economic growth on the other. Adding her own objection to these problematic assertions about "Asian values," Astorga maintains that human rights are universally valid and binding. From her perspective, particular cultures contribute to the normative universal claims by showing the rich and diverse ways in which these insights and values play out in practice. The struggles of local communities across time and cultures for liberty and justice serve to highlight the validity of these universal rights claims.

Astorga makes a valid point, though I suspect a deeper issue remains unaddressed. In my opinion, this debate on "Asian values" has been engrossed in political agenda right from its outset, and for this reason, it is not really a debate about Asian values. There is a basic question that cannot be addressed as long as the universal is framed in terms of human rights, and the particular is defended under the rubric of state sovereignty. It is the question about the precise relationship between the universal and the particular. While I myself do not deny the normative universal standards, I think a creative tension ought to be maintained between the universal and the particular. Recall that Aquinas' distinction between the primary and secondary precepts of the natural law aims to address precisely this tension between universal claims and particular contexts. Universal

[195] Final Declaration of the Regional Meeting for Asia of the World Conference on Human Rights (1993) at http://law.hku.hk/lawgovtsociety/Bangkok%20Declaration.htm. Accessed December 23, 2011.

principles or standards ought to be general and self-evident, in other words, *thinly* described, so as to allow for the contingencies within history and culture. Further, radical universalism can overlook the fact that particular local values and norms do reflect something of the genuinely human, which the universal standards aim to articulate. Therefore, the search for authentic human life can take place through the lenses of local cultures and traditions. There is a reciprocal relationship between the universal and the particular. On the one hand, the local culture can contribute to the fuller expression of human flourishing by offering its own distinctive perspective. It helps clarify, substantiate, and constantly mold the universal standards so that they become more truly the expression of human ideals. The local culture contributes not simply by again affirming the truths already discovered and captured in the normative universal claims, but by providing a rich context in which common human concerns and questions are raised, and how they are answered by this particular culture. On the other hand, the universal standards also challenge the local culture to aspire to what is more authentically human, and help expose moral blind spots and systemic injustice embedded within that particular culture, thus opening up new possibilities. Universality and particularity are not diametric opposites *in themselves*, but their claims do pull in opposite directions. The creative tension exists if one aspires to doing justice to both. It is the tension generated when one embraces one's own local culture, while accepting certain universal criteria for evaluating the normative claims within one's culture. In the context of globalization, the excessive promotion of universal standards can create pressure toward uniformity, while the ardent defense of cultural diversity can lend support to relativism, or disregard for

human rights. Between the two extremes exists the creative tension which allows fruitful dialogue and transformation.

1.6. CONCLUSION

In this chapter I defend the view that virtue ethics, of the Aristotelian-Thomistic tradition, is an adequate philosophical framework for contemporary medical ethics, because it not only promotes physician virtues, but also principles to guide decision and action in medical practice. The works of the authors discussed in this chapter have demonstrated *how* the central concerns of contemporary medical ethics can be addressed using the framework and language of virtue ethics. I maintain that an Aristotelian teleological framework provides the most adequate basis for virtue-based medical ethics, while the works of Aquinas, a further development of the Aristotelian framework, help resolve the apparent tension between virtue and principle. In light of Aquinas' works, the category of "patient needs" in Drane's theory can serve as the "proximate ends" for the development of physician virtues, while the "remote end" of physician virtues within the professional role is the human flourishing of patients. From an Aristotelian perspective, physician virtues are good for patients, because they enable physicians to deliver good medicine, thus ultimately promote the human good of patients. Medical virtues are also good for physicians, because they are intrinsic goods which partly constitute the human good of the physicians who practice them. Keenan's proposed cardinal virtues are consistent with this Aristotelian structure. Keenan's nature-based approach provides a sound basis for the virtues of *justice* and *fidelity* in medicine, because it accounts for the plurality of moral claims.

Contrary to what critics of virtue ethics often claim, there is no inherent conflict between virtue and principle, as the works of Aquinas have shown. In Aquinas' view, secondary precepts are action guides that can be generated in the pursuit of the acquired virtues. The virtues are said to provide the *telic* context for moral norms. As Veatch and other critics of virtue ethics are mostly concerned with the lack of action guides within a virtue ethics framework (or "naked virtue"), this Thomistic perspective helps strengthen the view that principle and virtue are both important aspects of a coherent ethical framework. This theoretical framework, which incorporates both virtue and principle, is more adequate than both pure virtue and pure rules.

There is a reciprocal relationship that ought to be acknowledged between the universal standards and the particular cultural norms. Because of this relationship, it is important to avoid both extremes: radical universalism on the one hand and cultural relativism on the other. Between these two extremes exists a creative tension that allows productive exchange between the universal and the particular.

Chapter II: JESUS' HEALINGS IN LUKE AND THEIR MORAL IMPLICATIONS

2.1. THE BIBLE AND VIRTUE ETHICS

In the first chapter, we have discussed the way Aristotle's teleological structure can provide the theoretical basis for virtue claims in medical ethics. Through the lens of virtue ethics, this chapter focuses on the Lukan healing accounts and their moral significance for Christian health care today. The chapter begins by explicating the approach that I take to the healing narratives, drawing upon the works of Joseph Kotva, Richard Burridge, and William Spohn. The chapter then engages some background issues specific to Luke-Acts, examines the healing practices in Jesus' historical context, and provides an exegetical study of five selected healing accounts from Luke-Acts. The chapter also elucidates some ethical implications for Christian medical practice in today's context.

2.1.1. Through the Lens of Virtue Ethics - Joseph Kotva

In his recent doctoral dissertation, Yiu Sing Luke Chan argues that an integrated Scripture-based ethics requires an equal emphasis on both biblical scholarship and ethical hermeneutics.[1] *Biblical scholarship* is the study of what the biblical text meant in its original context. This involves research into the historical context of the New Testament

[1] For a detailed discussion on the historical method and ethical hermeneutics, see Yiu Sing Luke Chan's doctoral dissertation, *Why Scripture Scholars and Theological Ethicists Need One Another: Exegeting and Interpreting the Beatitudes as a Scripted Script for Ethical Living,* Boston College, Theology Department, December 2010, 1-44.

text, namely the moral norms and customs at the time of Jesus in Judaism and the wider Greco-Roman world. *Ethical hermeneutics* refers to the task of theological ethicists who address the question, "What does the text mean for Christians today?" In the extended sense, it also involves the question of methodology, that is, which ethical theory can be used as the framework for the integration of these ethical insights into Christian praxis. In this dissertation, a Christian virtue ethic is used as the hermeneutical framework to link the gospel texts with Christian praxis. This Christian virtue ethic is informed by the works of theological ethicist Joseph Kotva who reconciles the Aristotelian virtue theory with Christian doctrines. Recall that Aristotle defines the human *telos* or the human good as "an activity of the soul, in accordance with virtue, with sufficient external goods, extended over a complete life."[2] In this context, the virtues are character traits and personal excellences that enable the person to achieve this end. In light of this teleological structure, Kotva proposes a Christocentric virtue theory by identifying Jesus with the *telos* of human life. Kotva maintains that sanctification in Christian doctrine is "a teleological concept" that involves personal transformation into the image of Christ. [3] To be Christ-like is the goal of the process of sanctification. If the structure of sanctification, or the Christian *telos*, is *conformity to Christ*, its content is Jesus who can be encountered in the New Testament.[4] Kotva holds that the human *telos* was revealed in history, in the life, teaching, death, and resurrection of Jesus. The implication is that our

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[2] Aristotle, *Nicomachean Ethics*, 1101a 14-16.

[3] Joseph J. Kotva, *The Christian Case for Virtue Ethics*, (Washington D.C.: Georgetown University Press, 1996), 93.

[4] Ibid, 87.

true end "must conform to the shape and pattern of Jesus' entire way."[5] Kotva believes that there is a basic agreement between virtue theory and Christian theology, though some areas in a virtue framework need to be modified and reformulated in order to be properly Christian.[6] Two such areas are: our dependence on God's grace; and that knowledge of our true nature and end is connected with a specific life in history: the life of Jesus. Kotva's alignment of the human *telos* with the theological concept of *conformity to Christ* has significant implications for Christian virtue ethics. The gospel narratives thus become mirrors of Christian virtues, for they reflect the true meaning and *telos* of human life.

2.1.2. Richard Burridge and the *Imitation of Christ*

From a different angle, the works of contemporary biblical scholar Richard Burridge have helped revive the *Imitation of Christ* motif in New Testament ethics because of his emphasis on the biographical genre of the gospels.[7] Through his parallel study of the four gospels and the ancient biographies, Burridge demonstrates that the four gospels belong to the genre of ancient□□□□□, which were generally written "among groups of people who have formed around a certain charismatic teacher or leader, seeking to follow after him…and seek to keep their memory alive."[8] There are significant implications of

[5] Ibid. Kotva acknowledges that the *telos* of sanctification toward which we continually strive cannot be fully reached in this life, in comparison with Aristotle's understanding of the human *telos*.

[6] Kotva, *The Christian Case for Virtue Ethics*, 76.

[7] Richard Burridge, *What are the Gospels? A Comparison with Graeco-Roman Biography* (Cambridge: Cambridge University Press, 1992); *Imitating Jesus: An Inclusive Approach to New Testament Ethics* (Grand Rapids, MI: Eerdmans, 2007).

[8] Burridge, *What are the Gospels?*, 80-81.

this biographical genre for New Testament ethics. First, as Jesus is the central character portrayed in the gospels, not only his *words* but also his *deeds* are of great ethical significance. Greco-Roman biographies present their subjects as models for imitation, so is Jesus presented in the gospels. Jesus is an exemplar for imitation in his sayings and sermons, and also in his healing acts, his outreach to the outcast and the poor, and in the events of his life, including the events of his final days. Second, as Burridge points out, the person of Jesus who is the central character in the gospels ought to be the locus and starting point for ethical reflection.[9] Third, in line with the ancient biographical genre, the depictions of Jesus in the four gospels aim to provide the portrait of a virtuous person as a model for Christian disciples to follow. In light of this, Luke's accounts of Jesus' healings provide a dynamic portrait of a good healer as an exemplar for others. If for Burridge, imitating Jesus is the central theme of New Testament ethics, it is well in line with central claims of virtue ethics. This approach highlights the role of Jesus as the moral exemplar, and the cultivation of the virtues which Jesus exemplified in the gospels.

2.1.3. William Spohn and the Analogical Imagination

The third author who contributes to a virtue ethics approach to the gospel texts is William Spohn, whose central proposal is that Jesus Christ is the paradigm for Christian moral life.[10] Through engaged reading of the Scriptures, Christians come to know Jesus and

[9] There are complex questions regarding the Jesus of faith versus the historical Jesus to which Burridge does not offer a satisfactory answer. Hays also faults Burridge for his attempt to get back to the historical Jesus in his book *Imitating Jesus*, rather than staying with the gospel witness which is more consistent with his biographical narrative approach. Richard Hays' review of Burridge, *Imitating Jesus* in *Scottish Journal of Theology*, 63(3): 331–335 (2010).

[10] William C. Spohn, *Go and Do Likewise: Jesus and Ethics*, (New York/London: Continuum, 2003), 1.

become transformed by his story. Spohn's methodology consists of three aspects which he believes can complement each other (i) the New Testament story of Jesus, (ii) the ethics of virtue and character, and (iii) the practices of Christian spirituality such as prayer and contemplation.[11] The Gospel message, according to Spohn, informs our moral life in two ways. First, the concept of the kingdom of God provides us with a metaphorical frame which informs our moral perception. Second, biblical images and stories help shape our character.[12] Spohn pays particular attention to the role of biblical images and stories in the shaping of moral dispositions and character. Through *analogical imagination*, these stories become for us "affective paradigms for moral dispositions", which enable us to respond in ways consistent with the story of Jesus.[13] The analogical imagination also shows us how to be faithful to Jesus in our particular situation.[14] Through prayerful reflection, the stories of Jesus' encounter with persons in the Gospel become paradigms for the way we continue to encounter Jesus and to respond to the risen Christ. The stories about Jesus and his disciples become the universal stories of Jesus and his followers down through the ages. Through analogical imagination, these stories become both a window into the life of Christ and his first disciples, and the mirror that reflects back on our own life of discipleship. Meditating on the stories of encounter

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[11] Ibid., 12.

[12] Ibid., 120.

[13] Ibid. Allen Verhey supports Spohn's defense of virtue ethics because virtue ethics can accommodate the narrative form of the New Testament; it is in line with the New Testament's emphasis on the "heart"; and it fits the New Testament's focus on Jesus as the paradigm of Christian perception and moral reasoning. Allen Verhey, review of *Go and Do Likewise: Jesus and Ethics* in *The Christian Century* (May 19, 1999), Vol.116(16), 565-6.

[14] Spohn, *Go and Do Likewise,* 186.

in the Gospels helps guide us to respond appropriately to Christ's invitation.[15] For instance, through analogical imagination, the story of Zacchaeus (Luke 19:1-10) is revealed as (i) the paradigm case "Jesus' welcome to Zacchaeus"; (ii) the recognition case "Jesus welcomes me"; and (iii) the problem case "I ought to welcome the outcasts accordingly."[16] As Spohn sees it, the exercise of analogical imagination is more than an intellectual practice, because of the living Christ active in our lives, who accepts us, guides us and invites us to respond.[17]

2.1.4. Point of Convergence – The Imitation of Christ

Note the convergence of Kotva's Christocentric virtue ethic and Burridge's emphasis on the *imitation of Christ*, and Spohn's assertion that Jesus Christ is the paradigm for Christian moral life. While Burridge insists that the gospel accounts of Jesus' acts provide examples for Christian disciples to imitate, Spohn suggests that this imitation can occur through the application of the analogical imagination in the reading of texts. Kotva's Christocentric structure also resonates with Spohn's stress on *putting on* "the mind of Christ." While Burridge calls attention to the gospel stories of Jesus' deeds, Kotva identifies Jesus' life as the content of the human good, Spohn highlights the practices by which Christian disciples are transformed by the stories and examples of Jesus. There is not only a convergence of the authors' works, they also complement each other, to give a robust approach to the study of biblical texts and how they ought to

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[15] Ibid., 127-128.

[16] Spohn, "Jesus and Moral Theology" in James Keating (ed), *Moral Theology: New Directions in Fundamental Issues*, (Mahwah, NJ: Paulist, 2004), 29-30.

[17] Ibid, 31-37.

transform Christian praxis. In light of this, the stories of Jesus' healings not only give us the paradigms for virtuous action, but also clues of the content of the human good that is revealed in Christ. Through the spiritual practices of prayer and meditation upon the biblical texts, we enter into the world of Jesus, and let Jesus enter into our world and transform us from within into the image of Christ, our true nature and telos. By meditating on the gospel texts of Jesus' healings, we encounter Christ the healer and his compassionate response to those who were sick and poor, and become transformed into compassionate healers in the pattern of Christ the healer. Through analogical imagination, we come to know the moral choices involved in our contemporary health care context, and what it means to imitate Christ through our choices and actions.

Before going on to the Lukan texts on Jesus' healings, it is important to acknowledge the essential place of the historical method in the study of biblical texts. In other words, an adequate reading of the gospel narratives cannot be without adequate biblical scholarship, of which the historical critical method is most widely accepted. As Daniel Harrington puts it, a more adequate approach to *New Testament ethics* is to combine both historical and hermeneutical concerns.[18] Harrington calls this combined approach the *historical-hermeneutical* method. As he explains,

> [This method] seeks to place the New Testament texts in their historical setting within the Roman Empire of the first century. It highlights the differences between that world and the world of the reader today, and challenges the reader to apply the principles of hermeneutical theory to the biblical texts: examining one's prejudices

[18] Note that the word *hermeneutics* in Harrington's usage refers to something quite distinct from what Chan means by *ethical hermeneutics*. Harrington's *hermeneutics* refers to the field of scholarship, with its own theories and principles, that discerns the meaning of a text written in a context different from that of the reader. Chan's *ethical hermeneutics* refers to hermeneutics in the extended sense, especially among ethicists. This extended sense of hermeneutics includes the question of methodology, with an emphasis on which philosophical structure that may be used to appropriate the moral teachings of the text for the modern reader.

> and presuppositions, acknowledging the historical and cultural distance between oneself and the text, attempting to make a fusion with the horizon of the text, and entering into a relationship of communion with the text.[19]

In summary, an adequate Scripture-based ethic demands not only good biblical scholarship, but also a philosophical structure that helps integrate the moral teachings, stories and images of the New Testament into the moral reasoning and behavior of present-day Christians. I take the view that the most adequate philosophical framework to serve this end is virtue ethics, particularly virtue ethics based on Aristotle's teleological structure. [20]

2.2. LUKAN TEXTS ON HEALING: AN INTRODUCTION

Though Jesus is depicted as a healer in all four Gospels, each evangelist presents Jesus' healings in the light of a distinctive theological perspective which not only provides the context but also adds nuances and texture to his healing acts. In other words, each evangelist offers a distinct portrait of Jesus the healer, and the evangelist's theological perspective ought to function as a hermeneutical key in the interpretation of the relevant healing narratives. This study examines the healing accounts in Luke-Acts for a number of reasons. First, the author of the third Gospel presents a very rich and attractive portraiture of the character of Jesus, which has bearing on a virtue ethics centered on the *imitation of Christ*. Second, Luke-Acts provides a crucial account of the early Church,

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[19] Daniel Harrington and James Keenan, *Jesus and Virtue Ethics: Building Bridges Between New Testament Studies and Moral Theology*, (Lanham/Boulder/New York/Toronto/Plymouth, UK: Rowman and Littlefield Publishers, 2002), 10-11.

[20] William Spohn, Daniel Harrington and James Keenan, Joseph Kotva, and Yiu Sing Luke Chan also share this view.

starting with "all that Jesus did and taught from the beginning until the day when he was taken up to heaven" (Acts 1:1-2); then the birth of the Church at Pentecost and the evolving mission in Jerusalem, in Judea and Samaria, then to the nations in fulfillment of Jesus' prophetic command (Luke 24:47-48, Acts 1:8). This provides a narrative link between the life and works of Jesus and Christian praxis. After his resurrection, the Lukan Jesus shows his disciples that he is "flesh and bones" (Luke 24:38-40) like one of us, a poignant sense of solidarity of the Risen Christ, the *telos* of Christian life, with us his followers.[21] Third and most importantly, through this narrative structure and through his depiction of the role of the Holy Spirit, the evangelist stresses that the Church's mission is in fact a *continuation* of Jesus' earthly ministry. Luke shows us that the apostles in the post-Easter era, animated by the same Holy Spirit that was at work in Jesus, heal and restore afflicted persons in the same way as Jesus did during his earthly ministry. At a certain ethical level, the healing narratives in Luke-Acts are congruent with the structure of virtue ethics. Not only does the evangelist see an exemplary pattern in Jesus' healings, he also provides accounts of Jesus' disciples performing healing acts in conformity with the examples set by Jesus the virtuous healer. At a deeper theological level, Luke even presents Christian disciples being transformed by the Holy Spirit into the messianic pattern of Jesus.[22] Luke's theological perspective keeps the Holy Spirit and grace clearly in sight in regard to Christian formation and praxis. His perspective also brings Christian ethics – and theological medical ethics in particular – into the sphere of

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[21] Luke Timothy Johnson draws out the sense of solidarity and family identity in the biblical tradition behind the phrase "flesh and bones." *The Gospel of Luke*, (Collegeville, MN : Liturgical Press, 1991), 410-411.

[22] Johnson, *The Acts of the Apostles,* 1.

salvation history, precisely because Christian disciples are a *continuation* on earth of the presence and ministry of Jesus Christ.

2.2.1. A Virtue Ethics Approach to the Healing Narratives in the New Testament

The gospel accounts of Jesus' healings have been largely examined under the rubric of "miracle stories," as determined by form criticism, and the focus has often been on the power that Jesus exercised, and what that power reveals about his identity and message.[23] This study takes a virtue ethics approach, which is in line with Burridge's biographical reading of the Gospels and the *imitation of Christ* motif.[24] This study seeks to integrate insights from the exegetical study of biblical texts into a theoretical structure of virtue ethics, paying particular attention to the parameters of moral formation: practice, character, exempla, and community. This chapter specifically examines five healing narratives in Luke-Acts in light of the Lukan theological perspective which provides context and texture to the texts. As this chapter demonstrates, the Lukan depiction of Jesus' healings provides a holistic view of health and healing. Luke also highlights a number of virtues attributable to God *and* to Jesus the healer: *mercy* or *compassion*, and *hospitality*. Mercy is the major theme in Luke's view of the history of salvation. "Mercy" refers to ἔλεος: God's mercy shown in the salvific plan which begins in Luke's infancy narrative, captured in Mary's *Magnificat* and Zechariah's *Benedictus* (Luke 1:50, 58, 72). Mercy (ἔλεος) also describes the action of the Good Samaritan who cares for the

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[23] Wendy Cotter, *The Christ of the Miracle Stories,* 1-4.

[24] Obviously the theological reading of Luke's Gospel is essential to this approach. This chapter later discusses the view that Jesus' miraculous healing acts are manifestations of God's promised salvation. See Tannehill, *The Narrative Unity of Luke-Acts,* 86-96.

wounded man (Luke 10:37). Mercy also refers to *ἐλέησόν*: the cry of the ten lepers (Luke 17:13), and of the blind beggar at Jericho (Luke 18:38, 39) to Jesus who subsequently heals them. "Compassion" refers to *σπλαγχνον*: God's compassion in the *Benedictus* (Luke 1:78). Luke's use of *ἐσπλαγχνίσθη* (moved with compassion) is associated with *seeing*: Jesus' feeling on seeing the sorrow of the widow of Nain (Luke 7:13), the Good Samaritan's reaction on seeing the wounded man (Luke 10:33), and the father's reaction on seeing the return of the lost son (Luke 15:20).[25] Hospitality refers to the way Jesus welcomes and cares for all who come to him, regardless of class, gender, social acceptability, or ethnicity. Luke's healing narratives therefore have significant implications for Christian medical ethics.

From her work on the literary form and likely use of anecdotes in Greco-Roman antiquity, Biblical scholar Wendy Cotter suggests that the miracle stories are used by the gospel narrator as *exempla*, to provide "some virtue to be admired and imitated."[26] In order to uncover the character of Jesus behind the miracle stories, she specifically examines Jesus' encounter with the petitioners in seven Markan miracle stories (1:40-45; 2:1-12; 4:35-41; 6:45-52; 7:24-30; 9:14-29; 10:46-52) and one Q/Lukan story (Luke 7:1, 3, 6b-9). From her study, Cotter identifies Jesus' virtues of *philanthropia* (loving concern for others),[27] and *praotes* (gentleness or meekness), also *epiekeia* (sweetness)

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[25] Though Luke uses the words mercy (ἔλεος) and compassion (σπλαγχνον) in different contexts, their meanings are in fact very closely related. See discussion in section 3.5.

[26] Cotter, *Christ of the Miracle Stories,* 5.

[27] As Cotter explains, the full definition of *philanthropia* in Greco-Roman antiquity is provided by Hubert Martin Jr, "affability, courtesy, liberality, kindness, clemency, … The philanthropos is gracious and considerate towards all with whom he associates, he is generous towards the needy, he is also merciful and clement towards his enemies." Hubert Martin Jr, "The Concept of Philanthropia in Plutarch's Lives," in AJP 82 (1961): 164-75, cited in Cotter, *Christ of the Miracle Stories,* 10.

which are most clearly shown in his reception of people who are on the fringes of society, non-elites, and foreigners.[28] Though Cotter does not explicitly name virtue ethics as her hermeneutical key, her work is generally in line with a virtue-ethics approach which I employ in this study. In addition, the social theme which Cotter touches on in her work – which deals largely with Markan texts – is a major feature of Luke's depiction of Jesus' healings, and therefore a significant part of this chapter.

2.3. THE GOSPEL ACCORDING TO LUKE: SOME BASIC ISSUES

The historical critical study of the Lukan texts on Jesus' healings requires some background knowledge of the author and of his works within their historical and literary contexts. This section provides a brief overview of some important issues related to scholarship on Luke-Acts.

2.3.1. Authorship

The Gospel of Luke and Acts are two volumes of a single literary work which accounts for a quarter of the New Testament canon.[29] The author of Luke-Acts is a well-educated person, an accomplished writer who is very familiar with both Old Testament literary traditions and Hellenistic literary techniques.[30] The Gospel prologue (Luke 1:1-4) indicates that the author is not an eyewitness of the ministry of Jesus, but likely a second

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[28] Ibid, 254-255.

[29] Johnson, *The Gospel of Luke*, 1. Joseph A. Fitzmyer points out that the study of Acts can help explain the Lukan redaction of the gospel material. In Fitzmyer's view, "in small ways Luke had actually been preparing by literary foreshadowing for details important for the end of his account." *The Gospel of Luke I-IX*, The Anchor Bible (Garden City, NY: Doubleday, 1981), 4.

[30] Fitzmyer, *The Gospel of Luke I-IX*, 35.

or third generation Christian.[31] The Third Gospel has traditionally been attributed to Luke, who appears in Philemon 24 as Paul's "fellow worker"; in Col 4:14 as "the beloved physician"; and in 2 Tim 4:11 as Paul's "sole companion."[32] In spite of recent arguments to the contrary, Fitzmyer defends the traditional view that Luke, a companion of Paul, was the author of the Third Gospel and Acts.[33] Luke was likely a non-Jewish Semite (probably a Syrian), native of Antioch, where he was "well educated in a Hellenistic atmosphere and culture."[34]

Luke, the Beloved Physician

Of some relevance to a study on medical ethics is the traditional claim that Luke was a physician. In Col 4:14 Luke is referred to as "the beloved physician," and this has become a Church tradition. Some have also argued in favor of this tradition by pointing to the way the Good Samaritan attended to the wounded man (10:34-35), and the omission of Mark's reference to the failure of "many physicians" to cure the woman in

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[31] Ibid, 35. Francois Bovon points to the masculine participle in 1:3 as an indication of the author's gender. Bovon, *Luke 1. A Commentary on the Gospel of Luke 1:1–9:50* trans. Christine M. Thomas, ed. Helmut Koester, (Minneapolis: Fortress Press, 2002), 8.

[32] Fitzmyer, *The Gospel of Luke I-IX*, 36. The identification of the Third Gospel with Luke has been a Church tradition since late second century.

[33] Fitzmyer believes the *We-Sections* of Acts (16:10-17; 20:5-15; 21:1-18; 27:1-28:16) support the traditional identification of Luke as the author of Luke-Acts, because it is likely that these "represent a diary of the author, later used in the composition of Acts." Fitzmyer, *Luke I-X*, 36-41. In contrast to Fitzmyer, Bovon believes that Luke "has had no immediate access or direct contact with the events that he narrates," and the We-Sections in Acts are "one of the artistic techniques he employs to substantiate the credibility of the story and to heighten its vividness." Nevertheless, Bovon thinks that, "Luke perhaps participated as a coworker on further missionary journeys and thus continued the Pauline mission." Bovon, *Luke 1*,13.

[34] Fitzmyer's argument is based on the form of Luke's name, the NT passages in which he is mentioned, and the ancient tradition about his Antiochene origin. Fitzmyer, *The Gospel of Luke I-IX*, 42-47. On the other hand, Bovon suggests that Luke might have been a Macedonian based on the circumstances related to the first occurrence of the We-passages, especially the appearance of the Macedonian man in Paul's dream (Acts 16:9-10). Bovon, *Luke,* 8.

Lk 8:43, and that she has spent all her money to no avail (cf. Mk 5:26).[35] W. K. Hobart in 1882 re-examined this claim by providing a detailed comparison of the language and style in Luke-Acts with the texts of Greek medicine, especially Hippocrates, Galen, Dioscurides and Arataeus. Hobart insisted that the author of Luke-Acts used more technical expressions which were found in medical texts, but not found in Mark's Gospel, a major source of Luke's Gospel.[36] However, in 1912 H. J. Cadbury provided a counter argument by showing that most of the "medical language" in Luke could also be found in the Septuagint, and in cultivated Hellenistic writers such as Josephus, Lucian, and Plutarch who were not physicians. Subsequently, G. A. Lindeboom also demonstrated that there is no similarity between the Lukan prologue and the prologues of medical texts by Galen, Hippocrates and Dioscurides.

In her recent volume, biblical scholar Annette Weissenrieder provides a study of Luke's healing narratives in parallel with texts from the Corpus Hippocraticum and other ancient medical manuscripts.[37] Her research focus is the *images* of illness in Luke's Gospel: the "barrenness" in Elizabeth and Zacharias, the healing of ten "lepers" in Luke 17:11-19, and Luke's redaction of three Markan healing narratives (Luke 8:43-48; 8:40-42, 49-56; 9:37-43). She argues that "the author of the Gospel of Luke intensifies the indicators of illness in the text" and that Luke "refers to an understanding of illness that

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[35] Fitzmyer, *Luke I-IX*, 52-53.

[36] Ibid, 51-52.

[37] Annette Weissenrieder, *Images of Illness in the Gospel of Luke,* 10-12, 28-32. While supporting Pilch's socio-anthropological approach, lauding his distinction between "illness" and "disease," Weissenrieder finds Pilch's division of the human body into three physical areas – heart/eye, mouth/ears, hands/feet – and his assignment of all women illness narratives to the third category unsubstantiated. Building upon Rupert Riedl's *binnensystem*, Weissenrieder proposes an explanatory model that transcends the division between the "internal" and the "external" of the human body.

was valid within the time and context of his work and his depictions of illness can be made plausible against a background of ancient medicine."[38] In her view, Luke consistently edited the Markan narratives using the illness construct of his time in order to "make his central message plausible: that of the presence of divine reality in the human sphere."[39] The Lukan author sought to provide "well-informed presentations of illness" in order to establish coherencies between the human and the divine realities.[40] Though her extensive work further highlights the eruditeness of the author of the Third Gospel, it does not resolve the question whether Luke was a physician.[41]

2.3.2. Date of Composition, Setting and Purpose

It is generally agreed that Luke-Acts was written not only after Mark's Gospel, but also after the fall of Jerusalem. Internal evidence suggests that Luke-Acts was written prior to the formation or circulation of the Pauline corpus. Fitzmyer defends the date used by

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[38] Weissenrieder, *Images of Illness in the Gospel of Luke,* 2.

[39] Ibid, 2.

[40] Ibid.

[41] Having examined the selected healing narratives in Luke's Gospel, Wessenrieder also studies the healings in Acts, focusing especially on the We-Section in Acts 28 (Paul's shipwreck, the serpent incident, and Paul's healing of the host's father who suffered from fever and dysentery), in parallel with Philo's writings. She concludes, "By making illness, healing, and images of the body in general plausible within the context of ancient medicine, they represent the solidarity and truth in the message of God's intervention in this world. Whether or not they may therefore be considered as ancient physicians remains uncertain… However, one thing is certain: only Luke is said to have worked as a physician in several traditions." Weissenrieder, *Images of Illness in the Gospel of Luke,* 357.

Fitzmyer comments on this point, "In fact, it makes little difference to the interpretation of the Lucan Gospel whether or not one can establish that its author was the traditional Luke, a sometime companion of Paul, even a physician. I think that some of the modern objections to the traditional identification are not all that cogent; hence the foregoing reassessment of them and of the traditional thesis. The important thing is the text of the Lucan Gospel and what it may say to Christians, regardless of the identity of its author." *Luke I-IX*, 53.

many of Luke-Acts, ca. 80-85 CE.[42] The place of composition remains uncertain, though it is highly unlikely to be Palestine.[43] The purpose of the two volumes is "so that you may know the truth concerning the things about which you have been instructed" (Luke 1:4 - NRSV). Fitzmyer translates *asphaleia* as *assurance* rather than *truth* to emphasize Luke's intention to assure his readers that the Christian teachings and practices of his day are rooted in the life and teachings of Jesus, thus to edify and to strengthen their fidelity to the Christian faith. The "assurance" is not simply about historical certainty but mainly doctrinal assurance.[44] Moreover, the historical perspective in the two volumes is the vehicle by which Luke presents Christianity as the "logical and legitimate outgrowth or continuation of Judaism."[45] This continuation means not only that the salvation promised to Israel has been brought about in Jesus, but also this salvation is being transmitted to the Gentiles through the missionary activities of the apostles.

2.3.3. Style, Structure and Themes

Luke typically attempts to improve on Mark's language and replaces or omits what might sound vulgar to the educated.[46] Luke avoids many of the Semitisms found in Mark, though he prefers a biblical tone in his narrative and follows the language and style of the

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[42] Fitzmyer, *Luke I-IX*, 57.

[43] Fitzmyer thinks Luke-Acts was certainly not written in Palestine, while Bovon thinks that "because of Luke's extensive travels, the matter of the place of composition is not a pressing concern. Rome still remains the next best alternative." Bovon, *Luke 1*, 9.

[44] Fitzmyer, *Luke I-IX*, 9.

[45] Ibid. Bovon believes Luke also aims "to quell Roman fears about the Christian mission" and advocates the social acceptance of the Christian Church. Bovon, *Luke 1*, 9.

[46] Bovon, *Luke 1*, 4.

Septuagint.[47] Luke generally tries to preserve the *sayings* of Jesus in Mark, though he omits or modifies a number of expressions of Jesus' emotions.[48] Fitzmyer notes the three different kinds of Greek in Luke's writings: the literary style of the prologues; the Semitic-flavored Greek of the infancy narrative; and the normal style in the bulk of the Gospel and Acts.[49]

Luke's Gospel has a clear structure, and can be easily divided into parts according to content.[50] After the prologue and the infancy narrative, Luke generally follows the order of Mark's Gospel, except for the insertion of the Lukan travel account 9:51-18:14. Luke also transposes the episode of Jesus' visit to Nazareth (4:16-30) to the beginning of Jesus' Galilean ministry, making it a "programmatic passage" which the Lukan Jesus fulfills through his preaching and healing.[51]

There are notable themes in Luke-Acts. Most significant is the unfolding of God's plan of salvation, by which God's promise of salvation is fulfilled. As Byrne points out, the author of Luke-Acts presents the stories of Jesus' birth and life, death, resurrection and ascension, then the birth and growth of the Church within an overall

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[47] Ibid.

[48] One such omission is Jesus' emotion on seeing the leper Luke 5:12-16, cf. Mark 1:41. This does not mean that Luke eliminates all expressions of Jesus' emotions. See Robert O'Toole, *Luke's Presentation of Jesus: A Christology* (Rome: Editrice Pontificio Istituto Biblico, 2004), 25-7.

[49] Fitzmyer, *Luke I-IX*, 109.

[50] Fitzmyer divides the Gospel into eight parts: 1:1-4 The Prologue; 1:5-2:52 The Infancy Narrative; 3:1-4:13 The Preparation for the Public Ministry of Jesus; 4:14-9:50 The Galilean Ministry of Jesus; 9:51-19:27 The Travel Account, Jesus' Journey to Jerusalem; 19:28-21:38 The Ministry of Jesus in Jerusalem; 22:1-23:56a The Passion Narrative; 23:56b-24:53 The Resurrection Narrative. Fitzmyer, *Luke I-IX,* 134.

[51] Robert F. O'Toole, *Luke's Presentation of Jesus: A Christology* (Roma: Editrice Pontificio Istituto Biblico, 2004), 17. Cf. Fitzmyer, *Luke I-IX*, 135.

schema of salvation which began way back with God's promise of salvation to Israel.[52] In the infancy narrative, Mary, Elizabeth, Zechariah, Simeon and Anna acknowledge that the salvation promised long ago to Abraham and his descendants has begun in the births of John and Jesus. The theme of fulfillment continues throughout the life and ministry of Jesus, and comes to its climax in his death and resurrection. The journey to Emmaus (Luke 24:19-21) dispels the conventional expectation about how this salvation ought to be, when the risen Jesus opens the minds of the disciples to understand how Scriptures were fulfilled in his life *and* his death. After Pentecost, Peter in his first speech explains the gift of the Holy Spirit in terms of the fulfillment of what God has promised through the prophet Joel (Acts 2:14-36).[53]

In line with this is the theme of salvation. Luke presents Jesus as savior (2:11), who saves through his acts of hospitality and reconciliation (7:50), healing (8:48, 50; 17:19; 18:42), and seeking out the lost (19:10). The apostles in Acts are entrusted with the same mission of Jesus: to preach the message of salvation (Acts 15:11; 28:28). The theme of salvation is prominent in the special Lukan parables of the lost (15:3-32).[54] In response, human beings are required to accept the prophetic critique and undergo a conversion which involves a "turning around" of one's life. Conversion is an important theme in Luke-Acts, because those who are to be part of the renewed People of God must

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[52] Byrne, *The Hospitality of God,* 12-13.

[53] Ibid. Byrne's schema of salvation history in Luke-Acts consists of three epochs: (1) the era of the promises, (2) the 'Day' of Jesus, and (3) the 'Day' of the Church which extends to the 'End Time.' The infancy narrative/preaching of John the Baptist connects the era of the promises with the 'Day' of Jesus. The passion narrative, resurrection, ascension, and Pentecost connect the 'Day' of Jesus with the 'Day' of the Church. The "pouring out of the Spirit" is the link between these epochs.

[54] Johnson, *Luke*, 23.

repent and redirect their life in accordance with the Word of God (Luke 3:7-14, 5:32; 10:13; 11:32; 13:3-5; 15:7-10; 24:47; Acts 2:37-40; 3:19; 5:31; 8:22; 11:18; 17:30; 20:21; 26:20). As Johnson points out, Luke particularly emphasizes the social aspect of conversion, which includes acts of hospitality and service to others.[55]

2.4. JESUS' HEALINGS IN LUKE: THE BACKGROUND

2.4.1. The Historical Context – Healing Practices in Jesus' Time

As Luke presented Jesus as a healer upon a particular socio-historical background, namely the Greco-Roman world and Second Temple Judaism, an overview of the health-related beliefs and healing practices of this era will enrich our understanding of his healing miracles. Weissenrieder outlines the three phases in the development of Greco-Roman medicine: the phase of the *Corpus Hippocraticum* in which writings were collected and integrated into the corpus; the phase of Greek or Alexandrian Medicine; and the phase of Roman Medicine.[56] During this last period, medicine of the Alexandrian epoch evolved into Greco-Roman medicine, with the emergence of the Methodist, the Pneumatic, and the Eclectic schools. Within the *Corpus Hippocraticum*, there are four discernible theories of illness: humoral theory (the theory of bodily fluids), theory of mechanics of excretion, theory of metabolism (heat and cold), and theory of environmental factors.[57] Therapeutic options of Greco-Roman medicine included

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[55] Ibid, 24. The themes of salvation and social justice are discussed further in connection with Jesus' healings in section 3.3.2. below.

[56] Annette Weissenrieder, *Images of Illness in the Gospel of Luke: Insights of Ancient Medical Texts*, (Tübingen: Mohr Siebeck, 2003), 43-9.

[57] Ibid, 51-4. Weissenrieder provides a very interesting study of the healing stories in Luke against the background of ancient medicine. This includes Elizabeth's 'barrenness' (Lk1); the healing of the ten

dietary intervention, medicinal remedies, and surgery. Dietetic measures were generally preferred to medicines; and medicines to surgery. Surgery was highly dangerous to the patient, and may harm the doctor's reputation should mishaps occur.[58] Physician and medical historian Guenter Risse describes a number of therapeutic practices based on the humoral theory that were used in second century CE Greco-Roman medicine: emetics, purgatives, cathartics, enemas, expectorants, diuretics, and bloodletting.[59] These were mostly performed within the sick person's home environment with family assistance.

In parallel with attempts to develop theories of medicine based on observable phenomena or philosophical principles,[60] people also sought divine assistance in times of distress. Drastic disasters such as famines and plagues were often ascribed to the gods, and elaborate religious rituals were used to ease the divine wrath. [61] Shrines of Asclepius were popular places where people sought healing through prayer, performing cleansing rituals and offering sacrifices to the Greek deity.[62] The cult of Asclepius, probably originated in Thessaly, became well established by the fifth century BCE, with the central *Asclepieion* built in Epidaurus ca 430 BCE.[63] It was a period of rapid urbanization, the

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'lepers' (Lk 17:11-19); the woman with the issue of blood (Lk 8:43-48); Jairus' daughter (Lk 8:40-42, 49-56); the boy with 'epileptic phenomena' (Lk 9:37-43).

[58] Vivian Nutton, 'Roman Medicine' in Lawrence Conrad et al, *The Western Medical Tradition, 800 BC to AD 1800*, (Cambridge: Cambridge University Press, 1995), 54.

[59] Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (New York: Oxford University Press 1999), 19-20.

[60] From the Corpus Hippocraticum and Philo's texts, there are two distinguishable groups of physicians. The first group formulates its medical texts based on philosophical principles; the second deduces its medical knowledge from observations in the practice of healing. Annette Weissenrieder, *Images of Illness in the Gospel of Luke: Insights of Ancient Medical Texts*, 348.

[61] Vivian Nutton, 'Roman Medicine,' 52-3.

[62] Guenter B. Risse, *Mending Bodies, Saving Souls*, 24-33.

[63] Ibid, 21.

growing tension between rich and poor, and the fear of deadly disease after the plague in Athens perhaps all contributed to the growth of this healing cult. In this same period the first public physicians of the secular Hippocratic cult also emerged in Athens. For Risse, the *Asclepieia* were in a broad sense created for healing purposes.[64] Temple healing was related to the popular Greco-Roman view that illness could sometimes be from the gods, and so is its cure. The temples of Asclepius and Sarapis functioned as centers of health advice and prognosis, as well as treatment. Upon entering into the compound, petitioners underwent a series of purification rituals, so as to arrive at the state of moral and physical purity before approaching the deity. Sometimes a change of dress to a white garment followed, to indicate the petitioner's readiness to participate in religious ceremonies. Petition prayers and sacrifice were both important in Greek cults. Sacrifice usually took the form of ritual killing of the animal, followed by a ritual meal. Sacred dogs and snakes were said to get around freely on the grounds. At times sacred dogs were used to lick the wounds of petitioners as a form of therapy.[65] As Risse explains, by coming to an *Asclepieion*, petitioners "entered into an association with the god," though a degree of 'shopping around' was not uncommon.[66]

Apart from medical interventions and temple healing rituals, people also turned to astronomy. 'Magical' remedies which involved amulets, chants and charms were widely

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[64] Ibid*,* 56.

[65] Lewis Richard Farnell, *Greek Hero Cults and Ideas of Immortality*, (Oxford : The Clarendon Press 1970), 234-279. Whether Luke's reference to the dogs licking Lazarus' sores in Luke 16:21 has any connection with this healing practice is unclear. Johnson interprets this detail purely in light of Jewish religious customs which regard things associated with dogs as unclean (Exodus 22:31; 1 Kgs 21:19, 24). Johnson, *The Gospel of Luke,* 252. Note that the story of the Syrophonecian woman (Mk 7:27-28 and Matt 15:26-27) which refers to "throwing children's food to the dogs," is omitted in Luke.

[66] Risse, *Mending Bodies, Saving Souls,* 57.

used. One of such magical remedies is a remedy for epilepsy involving the blood of a dead gladiator (or warrior, or street-brawler) as described by Marsinus the Thracian. However, Galen and Celsus offered a rationalized explanation of the efficacy of amulets, and had reservations about chants and charms. [67] In addition to physicians trained in Greco-Roman medicine, there were also other healers in Judea at the time of Jesus: itinerant healers and magicians; holy men who insisted on strict observance of Mosaic Law for it was the key to physical and spiritual well being. Some religious Jews rejected all forms of medical assistance and advocated sole reliance on divine help. [68]

2.4.2. Jesus' Healings - A New Dawn in Human History

Upon this background, Luke presents Jesus' healings as the dawning of a new era in which God's reign became manifestly present in our world (Luke 11:20). Theissen and Merz point out that this eschatological dimension was precisely the unique feature of Jesus' healing miracles. [69] According to Luke, Jesus' healing acts are to be seen within the broader context of God's salvific purpose.[70] In Luke, Jesus' audience recognize his authority and power (4:36). They also recognize God as the source of Jesus' extraordinary power. Luke frequently tells us that after Jesus' healing acts, the healed

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[67] Vivian Nutton, 'Roman Medicine,' 55.

[68] Ibid, 73.

John Pilch distinguishes between professionally trained physicians and folk healers in Jesus' time. Pilch identifies Jesus as a prophet-healer, or a folk healer in his socio-cultural context. Pilch, *Healing in the New Testament: Insights from Medical and Mediterranean Anthropology* (Minneapolis: Fortress Press, 2000), 89-103. On the other hand, Gerd Theissen and Annette Merz distinguish between magical healers and charismatic miracle-workers and identify Jesus with the latter group. Gerd Theissen and Annette Merz, *The Historical Jesus: A Comprehensive Guide,* tr. John Bowden (Minneapolis: Fortress Press, 1998), 304-309.

[69] Theissen and Merz, *The Historical Jesus: A Comprehensive Guide*, 309.

[70] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, *Luke,* 86-7.

persons or the people, or both, give praise to God (5:25-26; 7:16; 13:13; 17:15, 18; 18:43; 19: 37). In Jesus' healing ministry, God is actively engaged in bringing the promised salvation to the people. Luke also uses the language of the divine visitation in connection with Jesus' healings. In Luke 7:16, after Jesus' raising of the widow's son at Nain, the people glorify God and say "God has visited his people" (verb: *ἐπεσκέψατο*). This reference links Jesus' healing act with Zechariah's Benedictus in which the father of the newborn John praises God who has *visited* his people (1:68 *ἐπεσκέψατο*) to fulfill the promise of salvation made to Abraham.[71] Zechariah looks to the dawning from on high that will *visit* us (1:78 *ἐπισκέψεται*), a reference with messianic connotation to the birth of Jesus.[72] Luke sees Jesus' entry into Jerusalem as a time of the divine visitation that the people fail to recognize (Luke19:44). Then in Acts 15:14, God is said to have "visited" the Gentiles to gather from among them a people for his name. Connected with the theme of visitation is the exchange of hospitality between Jesus and the persons who receive him. As frequently seen in Luke, Jesus the visitor, or guest, who is received by others then becomes the host who welcomes them into the hospitality of God. Byrne sees in Jesus' healings concrete examples of the hospitality of God offered to and received especially by the poor and the dispossessed.[73]

In line with Luke's theme of fulfillment of the divine promise is his frequent reference to salvation (*σωτήρια, σωτήριον, σωζω*), in connection with Jesus' healing acts

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[71] Johnson explains that "visit" (episkeptein) is used in the Torah to indicate God's interventions in history (Gen 21:1; 50: 24; Exod 4:31; Ruth 1:6; Ps 105:4 [Septuagint]). Luke uses it in the same sense (Luke 1:78; 7:16; 19:44; Acts 7:23; 15:14). Johnson, *Luke*, 45-6.

[72] Johnson points out that "from on high" simply means "from God," and "dawn" (*anatole*) occurs three times in the Septuagint, in each case with a messianic connotation. Johnson, *Luke,* 47.

[73] Ibid., 196.

(Luke 6:9; 8:36, 48, 50; 17:19; 18:42),[74] and also in the context of hospitality and reconciliation with God (Luke 7:50; 19:9). That Jesus' healing acts are in fulfillment of God's salvific purpose is made clearer in Jesus' inaugural address (Luke 4:18-19); in Jesus' summary of his healing ministry (Luke 7:22), and Jesus' reference to the fulfillment that prophets and kings longed to see (Luke 10:23-24). In Luke's view, there is a connection between Jesus' healings and God's redemptive purpose which embraces all dimensions of life. In other words, Jesus' healings are connected with the coming of God's reign. In Luke 9:2 Jesus sends out the Twelve to proclaim the good news and to heal, the pattern repeated in the commission of the seventy in Luke 10:1-24. In Luke 9:11, Jesus welcomes those who come to him, speaks to them about the reign of God, and heals those who need to be cured. In Luke 11:20, Jesus directly links the healing acts which he performs – by the "finger of God" – with the coming of God's reign. In Jesus' ministry, the power of Satan which has controlled human life is broken, and God's reign is at hand. Then in the parable of the great banquet, Jesus refers to "the poor, the crippled, the blind, and the lame" being invited to the banquet of God's reign (Luke 14:21). Jesus refers to a similar list of disadvantaged persons whom he healed and ministered to in fulfillment of the divine promise (Luke 7:22).[75] This social theme is consistently an integral feature of Luke's depiction of Jesus' healings.

2.4.3. To Bring Good News to the Poor: Inauguration of Jesus' Ministry Luke 4:14-30.

[74] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, 87.

[75] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, 89.

Luke's healing narratives are framed by a key scene in the Gospel: the inauguration of Jesus' ministry in Nazareth.[76] That Luke places the episode first in his account of Jesus' public ministry (cf. Mk 6:1-6a and Mt 13:54-58) suggests that the rest of the Lukan account should be interpreted in light of it.[77] The episode shows a fresh interpretation of the Isaiah text (Isa 61:1-2) in a way that has particular significance for the poor and the downtrodden of Jesus' day. The prophetic text, originally announced to the exiles returning to Jerusalem, is now interpreted as the divine promise which is to be fulfilled in the person, words and deeds of Jesus.[78] The anointing by the Spirit is understood as a reference to Jesus' baptism (3:22) when he is empowered to carry out what the prophet had envisioned.[79] The "poor" to whom Jesus is sent include not only the economically impoverished but all those who are marginalized or excluded from participation in community life. Jesus' ministry to the "poor" is a major theme in the Gospel (6:20; 7:22; 14:13, 21; 16:20, 22).[80]

The outstanding theme in the Isaiah text, especially in Luke's redacted version, is one of liberation, or release (ἄφεσις). Earlier in the Gospel, Luke has twice referred to the release from sin in connection with the ministry of John (1:77; 3:3). For this reason,

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[76] Ibid, 45.

[77] Robert C. Tannehill, *Luke, Abingdon New Testament Commentaries Series* (Nashville, Abingdon Press, 1996), 91.

[78] Fitzmyer, *Luke I-IX,* 529. Cf. Byrne, *The Hospitality of God,* 47.

[79] Fitzmyer understands Jesus' baptism (Luke 3:21-22) as a prophetic anointing, rather than a political, kingly sort of anointing. Furthermore, in Acts 10:37-38 (the wording echoes Isa 61:1, and Luke 4:18), Fitzmyer concedes that Luke does interpret the baptism of Jesus as a messianic anointing, though the idea of a messianic anointing is not clear in the baptism scene itself. Fitzmyer, *Luke I-IX,* 482, 532.

[80] Johnson, *Luke,* 79.

release of captives could be understood as liberation from the captivity of sin.[81] In line with this, *giving sight to the blind* can be interpreted as the release into the light of day those who have been long detained in dark prisons.[82] In addition, Jesus' ministry also fulfills this promise in the healing of persons with physical blindness (7:21; 18:35). The phrase "to let the oppressed go free," taken from Isa 58:5-7, originally indicating the demand of justice that God requires of Israel, is now being fulfilled in the ministry of Jesus.[83] In Luke's view, spiritual release must impact upon the totality of human life, including the reordering of the socio-economic structures of society. The final element is the proclamation of "an acceptable year of the Lord" (ἐνιαυτὸν κυρίου δεκτόν). Fitzmyer interprets this as "a period of favor and deliverance" which specifies the Period of Jesus.[84] In line with this, Byrne explains that to proclaim "an acceptable year of the Lord" is the core of Jesus' ministry and that of the Church because it signifies "the time when people are accepted, not judged" by God.[85] Jesus' message does call for personal conversion, though Byrne stresses that the divine gift of acceptance occurs *before* conversion and makes it possible.

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[81] Byrne, *The Hospitality of God,* 48. In Fitzmyer's view, this might refer to release of imprisoned debtors. *Luke I-IX*, 532. Tannehill believes that "release" is a broad category which includes at least (1) release for the economically poor, (2) release through healing and exorcism (4:31-5:16); and (3) "release" of sins (*αφεση αμαρτιων*). *The Narrative Unity of Luke-Acts,* Vol. 1, 103.

[82] Byrne, *The Hospitality of God,* 48.

[83] The link between Isa 58:5-7 and the original text of Isa 6:1-2 is the word release (aphesis). This word occurs frequently in connection with two practices required by the Torah: the first is the remission of debts and release from the bonds of slavery on the Sabbatical Year (Deut 15:1-18); the second is the cancellation of all debts, including the return of acquired land to its original owners, on the fiftieth or Jubilee Year (Lev 25:8-12). Byrne, *The Hospitality of God,* 49. Cf. Johnson, *Luke,* 79.

[84] Fitzmyer, *Luke I-IX,* 533. Johnson explains that, though some scholars believe that Luke's Jesus is announcing the eschatological Jubilee year when "all debts would be remitted and all slaves manumitted," the Gospel does not provide further support for this point. Rather, the Lukan Jesus' liberating work is performed through personal forgiveness, healings, exorcisms and teaching. Johnson, *Luke,* 81.

[85] Byrne, *The Hospitality of God,* 50.

The reaction of Jesus' townspeople helps highlight the nature of Jesus' ministry which must not be contained within social or ethnic boundaries. Fitzmyer explains the abrupt transition in the people's response to Jesus, from favor to hostility (4:22-23), by suggesting that the Lukan passage is a conflation of two different stories, one is a fulfillment story ending in success; the other is a rejection story.[86] On the other hand, Byrne sees in 4:22 already the people's attempt to claim Jesus for themselves by labeling him "Joseph's son," putting him in a box with which they are comfortable. This explains Jesus' comments as a firm resistance to their attempt to confine and control him.[87] Jesus compares his ministry to that of Elijah and Elisha, the two prophets who were sent to minister to Gentiles outside the boundaries of the people of Israel. Jesus' prophetic mission has a universal scope, because God's visitation is "for the poor and oppressed of all nations."[88] It is this very suggestion that arouses the violent reaction of his audience. The prophet of God's acceptance is himself not accepted by his own people, who refuse to accept the universal nature of the divine visitation that Jesus is inaugurating, and fail to undergo the conversion required.[89]

It is also significant that Luke's Jesus cites the proverb "Physician, heal yourself!" (4:23) in reference to himself.[90] In 4:24, Luke's Jesus applies to himself the title of prophet and recounts the stories of Elijah and Elisha, two major prophet-healers of the

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[86] Fitzmyer, *Luke I-IX,* 526-30.

[87] Byrne, *The Hospitality of God,* 51.

[88] Johnson, *Luke,* 82. Byrne, *The Hospitality of God,* 51-2.

[89] Byrne, *The Hospitality of God,* 53.

[90] The trained and credentialed healers of Jesus' time were known as *iatros*, the term used in Luke 4:23; 5:31; and 8:43 which is often translated as "physicians." In Luke 5:31, Jesus uses the image of the physician healing the sick to explain his outreach to social outcasts. The reference to the powerlessness of physicians in regard to the woman's illness in 8:43 highlights Jesus' healing power and the woman's faith.

Hebrew Bible to elucidate his mission. The two stories that he chooses further confirm Jesus' self-understanding as a healer: Elijah who was sent to the widow of Serepta later raised her son back to life (1 Kgs 17:17-24); Elisha cured Naaman the Syrian of leprosy (Luke 4:27 cf. 2Kgs 5:1-14). At this inauguration event, Luke's Jesus sees physical healing as an integral part of his messianic ministry in the same tradition of the great prophet-healers of the Hebrew Bible. Later, the wording of Luke's account of Jesus healing the leper (5:12-16) resonates with the story of Elisha's cure of Naaman in the Septuagint.[91] Again Luke's depiction of Jesus raising the widow's son at Nain (7:11-17) reflects the story of Elijah's raising of the widow's son at Serepta.[92] Consistent with the ministries of these great prophet-healers who reached out to Gentiles, Jesus' gift of healing also extends beyond ethnic and social boundaries, to bring life to the Samaritan (Lk 17:12-19), the Gerasene man (Lk 8:26-39), and member of a Roman's household (Lk 7:1-10). This account thus illustrates further the connection between Jesus' healings and God's salvific purpose which embraces the totality of human life. At this key event in the gospel narrative, Luke's Jesus highlights the farther reaches of God's saving purpose which is being fulfilled in his own person and ministry. Though it is not known for certain whether Luke was a physician, this episode and subsequent healing accounts suggest that Luke at least has a deep appreciation of illness and healing, and this appreciation influences his presentation of Jesus' healings.

2.4.4. The Poor and the Excluded in Luke

[91] Especially between the Lukan text and 2Kgs 5:3 *LXX*. Fitzmyer, *Luke I-IX*, 574.

[92] Johnson points to Luke's reference to the woman as a widow (7:12) and how Jesus presented the son to his mother after the cure (7:15), which are in parallel with 1 Kgs 17:20 and 1 Kgs 17:23 in the Septuagint respectively. Johnson, *Luke,* 118-119.

Scholars differ significantly in their interpretation of "the poor" in Luke. Some argue that Luke's motif of poverty has literary or spiritual significance,[93] while others maintain that Luke refers specifically to the economically poor and downtrodden.[94] Byrne rightly points out that there is more than one layer of meaning in Luke's motif. According to Byrne, Luke certainly refers to the economically poor and such texts as the *Magnificat* and the Beatitudes ought to inform the way Christians perceive economic and social justice issues.[95] At the same time, "the poor" in Jesus' day had become a standard self-identification of those in Israel who waited for salvation from the Lord – like Simeon and Anna in the infancy narrative. "The poor" in this perspective indicates the afflicted who await salvation, including those who do not suffer primarily from economic poverty. Nevertheless, in Luke's Gospel Jesus frequently intervenes on behalf of the poor and the marginalized, often by defending them against those in positions of power.[96] As Tannehill points out "God's mercy on the physically hungry and economically poor is a major theme in Luke."[97] This theme comes through especially in the "programmatic" texts in Luke's Gospel: the *Magnificat* (1:46-55), Jesus' inaugural address in Nazareth

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[93] For instance, Luke Timothy Johnson, *The Literary Function of Possessions in Luke-Acts,* SBLDS 39 (Missoula: Scholars Press, 1977); *Sharing Possessions Mandate and Symbol of Faith* (Philadelphia Fortress Press, 1981); David Peter Seccombe, *Possessions and the Poor in Luke-Acts,* Studien zum Neuen Testament und Seiner Umwelt, Serie B, Band 6, (Linz: A. Fuchs, 1982). Seccombe argues that "in a number of key passages Luke uses 'the poor' as a soteriological term characterizing Israel in her great need of salvation," and the Lukan passages on renunciation "are not intended to teach a general ethic of renunciation, but to inculcate a certain view of 'limitless' discipleship," 19.

[94] For instance, Philip Esler, *Community and Gospel in Luke Acts,* SNTSMS 57 (Cambridge: Cambridge University Press, 1987); W. E. Pilgrim, *Good News to the Poor* (Minneapolis: Augsburg Publishing House, 1981); Mary Ann Beavis, "'Expecting Nothing in Return': Luke's Picture of the Marginalized," *Interpretation* 48, 1994, 357-368.

[95] Byrne, *The Hospitality of God,* 66.

[96] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 103.

[97] Ibid, 127-8.

(4:18:19), and the Beatitudes (6:20-26).[98] Jesus' reply to John the Baptist in 7:22 links Jesus' healing ministry with the proclamation of the good news to the poor.[99] The story of the great banquet (14:16-24) lists the poor, the crippled, the blind and the lame as those received into the messianic banquet, in contrast with people of wealth who decline the invitation. As Esler points out, the concern for the poor in Jesus' teachings – exemplified by his behavior – is radically at odds with the cultural norms of the Greco-Roman world, though it is consistent with the Hebrew prophetic tradition.[100] Similarly, Jesus' critique of the rich (Luke 12:21; 16:13; 18:22-32) is also in line with the Hebrew tradition and foreign to Greco-Roman values. Esler believes that Luke's radical view of salvation even includes "the elimination of injustice, the alleviation of the sufferings of the poor and the destitute" in the here and now.[101] More than other evangelists, Luke stresses the social aspect of conversion. As Johnson puts it, "as God's visitation of the people for salvation was a revelation of his loving-kindness above all to the outcast (Luke 1:50, 54, 58), so are his people to reach out in love to all without thought of repayment (6:32-36; 10:27-37)." [102]

Related to this is Luke's theme of reversal, which occurs at the visitation of the people by the Prophet. In the Gospel, those who are rich and powerful typically reject the Prophet, for they already receive consolation in society. [103] As a result, people of wealth

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[98] Beavis, "Expecting Nothing in Return," 359-60.

[99] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 128.

[100] Philip Esler, *Community and Gospel in Luke Acts,* 187-190.

[101] Ibid, 193.

[102] Johnson, *Luke,* 24. Cf. Tannehill, *The Unity of Luke-Acts,* Vol. 1, 132.

[103] Johnson, *Luke,* 22-23.

and power are "cast down" or "lowered" by God. In contrast, the poor and the outcast accept the Prophet, and they in turn are "raised up" to become part of the restored People of God. Among "the poor" are the crippled, the lame, the blind and the deaf, tax-collectors, public "sinners" and all those ritually excluded from full participation in the life of the people. The repeated pattern in Luke suggests that Jesus' good news not only challenges personal attitudes and behavior, but also exposes the social structures underneath such attitudes and behavior. As Tannehill puts it,

> Human society perpetuates structures of injustice and exclusion, but God intervenes on the side of the oppressed. The disruptive effect of this intervention is often presented in Luke as a reversal of the structures of society: those with power, status, and riches are put down and those without them are exalted.[104]

This reversal is found in the Magnificat (1:51-53), also in Simeon's prophecy concerning the fall and rise of many in Israel (2:34); the Beatitudes (6:20-23, 27); and the parable of the Great Banquet (14:16-24). [105] Luke also presents often and in positive light the role of women,[106] and his portrayal of Mary is symbolic of the way God intervenes to "lift up" the poor and the lowly. Part of this reversal is also the inclusion of Samaritans and Gentiles among the People of God. [107]

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[104] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 109.

[105] Ibid, 110.

[106] See Barbara E, Reid, *Choosing the Better Part?: Women in the Gospel of Luke* (Collegeville, Michael Glazier Books, 1996); "Beyond Petty Pursuits and Wearisome Widows: Three Lukan Parables" *Interpretation*, July, 2002, Vol.56(3), p.284(12). On the other hand, there are also critics of Luke's presentations of women, for instance, Mary Rose D'Angelo, "Women in Luke-Acts: A Redactional View," JBL 109/3 (1990) 441-461; Jane Schaberg, "Luke" *The Women's Bible Commentary,* ed. Carol A. Newsom and Sharon H. Ringe (Louiseville: Westminster/John Knox, 1992), 275-292; Elaine M. Wainwright, *Women Healing/Healing Women: The Genderization of Healing in Early Christianity* (London: Equinox, 2006). Wainwright faults Luke for his overt tendency to present illnesses as manifestations of demonic possession, for this represents an attempt to discredit women healers within the community. However, Wainwright does not provide examples of such representation of women healers in the Third Gospel.

[107] Johnson, *Luke,* 22.

2.5. AN EXEGESIS OF LUKAN HEALING TEXTS

2.5.1. Healing of a Leper – Luke 5:12-16 (Mk 1:40-45/Mt 8:1-4)

[12] Once, when he was in one of the cities, there was a man covered with leprosy. When he saw Jesus, he bowed with his face to the ground and begged him, 'Lord, if you choose, you can make me clean.' [13]Then Jesus stretched out his hand, touched him, and said, 'I do choose. Be made clean.' Immediately the leprosy left him. [14]And he ordered him to tell no one. 'Go', he said, 'and show yourself to the priest, and, as Moses commanded, make an offering for your cleansing, for a testimony to them.'[15]But now more than ever the word about Jesus spread abroad; many crowds would gather to hear him and to be cured of their diseases. [16]But he would withdraw to deserted places and pray.

Context

After the call of the first disciples, Luke reports a number of episodes (5:12 - 6:11) which particularly illustrate the way Jesus ministers to people who are marginalized because of illness or because they carry the stigma of public sinner.[108] These episodes highlight both Jesus' power to bring wholeness and healing to human life, and Jesus' special disposition toward the poor and the marginal persons. That these healing accounts immediately follow Jesus' call of the first disciples also suggests that they have a pedagogical purpose for Jesus' disciples.

Details of the Healing Account

The account shows Luke's fidelity to the Markan source, though Luke also makes some editorial changes characteristic of his style. The introductory phrase "in one of the cities" links the episode with Jesus' Galilean ministry.[109] While Mark refers to the petitioner as a "leper," Luke describes him as "*full of leprosy*." It is not clear whether Luke

[108] Byrne, *The Hospitality of God,* 58.

[109] Fitzmyer, *Luke I-IX,* 571.

personifies leprosy here as he did with the fever (4:38-39),[110] but it is clear that "this disease separates the afflicted from fellowship with God" and causes suffering and death.[111] The term *leprosy* (*λέπρα*) in the Bible does not indicate a specific disease diagnosis (such as Hansen's disease) in today's medical usage, but it includes a wide variety of skin diseases, some of which are contagious and incurable, while others can be cured.[112] The Hippocratic writings listed *lepra* among a group of ailments that cause disfigurement, itchiness or loss of hair. [113] Leviticus 13-14 describes leprosy (*sara'at*) as a condition affecting the skin which can cause swelling, itchiness, discoloration and loss of hair, the exposure of raw flesh, or the appearance of white scaling on sores.[114] According to the law prescribed in Leviticus 13:45-46, persons affected by leprous disease have to wear torn clothes, have their hair disheveled, to live outside the camp, and to cover their upper lip and cry out in warning to persons who might come their way. For the family and the community, "these people are as though dead, and the ritual of separation is reminiscent of that of mourning."[115] Among the rabbis, cure of leprosy was considered as difficult as raising a person from the dead.[116] There was also the idea that leprosy was the result of sin (cf. Lev 14:19), and it is among the diseases that will be

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[110] Cf. Johnson, *Luke,* 92.

[111] Bovon, *Luke 1,* 175.

[112] I. Howard Marshall, *The Gospel of Luke: A Commentary on the Greek Text* (Exeter: The Paternoster Press, 1978), 208. Wendy Cotter discusses the origin of the confusion, which began with Pliny the Elder (*Natural History*, 26.5), between the skin ailments (which the Greeks called *lepra*) and *elephantiasis* (which the Greeks called *leprosy*). Cotter, *Christ of the Miracle Stories*, 23- 25. See also Jacob Milgrom, *Leviticus 1-16*, (New York: Doubleday, 1964), 816-7.

[113] Hippocrates, *Affections 35; Diseases I; Diseases II* (trans. Paul Potter; LCL; Cambridge, Mass.: Harvard University Press, 1988), 59. Cited in Cotter, *Christ of the Miracle Stories*, 26.

[114] Cf. Cotter, *Christ of the Miracle Stories*, 24- 27.

[115] Bovon, *Luke 1,* 175.

[116] Marshall, *The Gospel of Luke,* 208.

eradicated in the messianic age.[117] If the individuals no longer have the disease, they can be restored to society only after undergoing examination by the priest and offering sacrifice of guilt-offering (Lev 14). Through the ritual, the individual is declared clean in the sight of God, is reintegrated into the community and lives again.[118]

Seeing Jesus, the man shows reverence by bowing his face to the ground and addresses Jesus as Lord (*kyrie*). The words of the petitioner, "*if you choose, you can make me clean"* express a deep confidence in Jesus' healing power.[119] The implication is that Jesus can cure him by an act of his will alone. Having compared Jesus' ministry with that of the prophets Elijah and Elisha, making explicit reference to Elisha's cure of Naaman from leprosy (4:27), Luke likely has the Old Testament story in mind in his redaction of the Markan account.[120]

In response, Jesus stretches out his hand, and touches the man. In the Septuagint, reaching out to distressed human beings has a salvific significance because the Lord has stretched out his hand to his people.[121] Jesus' touch establishes direct contact with the man, expressing by gesture his unreserved willingness to heal and to comfort in the face of religious and cultural taboo. As Cotter puts it, "Jesus responds to the man's approach by reaching out to effect the contact between them… Jesus joins the man in overturning the Torah rules, and even more so, by establishing the touch."[122] More than Mark and Matthew, Luke frequently depicts Jesus healing by touching or laying his hands on the

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[117] Ibid.

[118] Bovon, *Luke 1,* 175.

[119] Ibid.

[120] Fitzmyer, *Luke I-IX,* 574.

[121] Bovon, *Luke 1,* 175.

[122] Cotter, *Christ of the Miracle Stories*, 39.

afflicted (4:40; 5:13; 8:54). However, in Luke's Gospel, direct contact with Jesus is not necessary for effecting the cure, for Jesus also cures by a word of healing, as in the case of Peter's mother-in-law (4:39), the cure of the paralytic (5:17-26), the cure of the blind man at Jericho (18:35-43), and the cure of the Centurion's servant (7:2-10).[123] In this healing account, Jesus' touch goes against what is prescribed by the Leviticus purity law, and therefore cuts across the boundary between the clean and the unclean. By touching the leper, Jesus becomes identified with the ritually unclean who are despised and excluded from society.

In answering the request, Jesus uses the man's own words (θέλω, καθαρίσθητι), showing his attentiveness and his willingness to engage the man on his terms.[124] Jesus communicates verbally and non-verbally compassion and care in response to the plight of the leper. Luke reports the immediate cure as a result of Jesus' intervention. In meeting the leper where he is, by reaching out and touching him, Jesus makes him clean and restores him to health and to ordinary life. Jesus then instructs the man to keep silence about the cure, but to show himself to the priest for purification ritual as prescribed by Mosaic Law for re-integration into the community. This shows that Jesus both knows and respects the Torah, and his touching the leper was not due to ignorance or disrespect for Torah regulations. As Byrne sees it, Jesus' works of compassion "place pressure on the Law of Moses" but do not overthrow it.[125]

The story closes with the crowds gathering to hear Jesus and to be healed. Again

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[123] Cf. Ibid.

[124] Ibid, 39-41.

[125] Byrne, *The Hospitality of God,* 59. Fitzmyer also notes Luke's emphasis on the continuity between Christianity and its Mosaic roots. Fitzmyer, *Luke I-IX,* 572.

Jesus withdraws to deserted places to be with God in prayer (cf. 4:42-43).[126] We see a reversal of places that occurs between Jesus and the leper as a result of the healing encounter. As the story begins, Jesus is "in one of the cities" when he encounters the man who is excluded from society because of illness. As the story ends, the man is healed and re-integrated into society, while Jesus retreats to deserted places. This brings out the personal costs of the work of healing, from which Jesus is not exempted.[127]

Significance for Medical Ethics

This healing narrative is presented by Luke within a broader context of God's salvific purpose.[128] It especially resonates with the theme of God's loving *mercy* by which God intervenes on behalf of the lowly and lifts them up (1:50-55). God's mercy, originated from God's fidelity to the covenant, is especially shown in God's care for the poor and the disadvantaged.[129] In this context, Jesus' healing act is a concrete example of the mercy of God toward the poor and the outcast. Luke's healing narrative highlights two characteristics of this virtue in Jesus. First, Jesus' mercy is shown in his reaching out to the afflicted person who is banished to the margins of society. Jesus' act of mercy extends beyond the bounds of ordinary convention, and like the parable of the Good Samaritan (10:25-37), it challenges readers to re-examine their own criteria for inclusion/exclusion. Second, given the context of Leviticus law, Jesus' touching the

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[126] Bovon, *Luke 1,* 177.

[127] Other examples of the inconvenience or persecution that Jesus is subjected to as a result of his healings include: the cure of a man with dropsy on the Sabbath 6:6-11; cure of the Geresene demoniac 8:37; and the cure of the woman with a bent back 13:10-17.

[128] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, 86-7.

[129] O'Toole, *Luke's Presentation of Jesus: A Christology,* 70.

leper shows his solidarity with the afflicted man and the willingness to share in his suffering and his shame. As James Keenan puts it, mercy is "the willingness to enter into the chaos of others."[130] Luke frequently depicts Jesus keeping company with the social outcasts of his day, the "sinners and tax collectors" in order to bring them healing and salvation (5:29-32; 15:1-2; 19:7-10). Luke particularly preserves the detail of the physical contact in this healing narrative, for Luke describes not only solidarity, but *healing* in Jesus' touch. In this age of litigation against sexual abuse by the clergy and physicians, in many cases because of inappropriate touching, this story highlights the tremendous significance of the healer's touch. Jesus' touch, or the laying of his hands on patients, is a distinctive feature in Lukan accounts of Jesus' healings.[131] Jesus' touch is the beginning of human contact for the man who has been ostracized because of illness. This touch is deeply humanizing for the man, for it has in itself, restored his dignity as a human person. By this gesture, Jesus joins the man in overturning the religious and social expectations that aim to protect healthy and "clean" persons like Jesus from lepers like him.[132] By affirming the man's decision in approaching him for help, Jesus calls into question the self-discriminating demands of the law on the sufferers of this disease.

This healing account is equally a good illustration of the virtue of *hospitality* by which Jesus receives persons who are despised and cast out from society. In 7:16, Luke uses the language of the divine visitation in connection with Jesus' raising of the widow's

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[130] James Keenan, *The Works of Mercy: The Heart of Catholicism,* 2nd ed. (Lanham, Md. : Rowman & Littlefield, 2005), 4.

[131] Note Luke's summaries of Jesus' cures 4:40-41, 6:17-19 which follow Mark 1:32-34; 3:7-12, with a special emphasis on the laying on of hands or the touch.

[132] Cf. also the purification rituals of the Asclepieia in the Greco-Roman world at Jesus' time, by which petitioners are to be cleansed prior to approaching the deity.

son at Nain, which resonates with Zechariah's grateful joy that God has visited his people (1:68).[133] Through Jesus' healing act, the hospitality of God is extended to this marginal person, so that he too may be counted among the People of God.[134] This healing account is symbolic of the divine visitation, in which God visits the people, listens to their plea, and sets them free from illness and estrangement.

Another point of connection with medical ethics is Luke's holistic view of healing and health. After the cure, Jesus gives immediate instructions to the man to facilitate his integration into society (cf. 17:14). For Luke, healing is more than physical cure, for it includes also the restoration of the person's relationships with God and with others in community. Luke often accents the social aspect of Jesus' healings. In the healing of Jairus' daughter, Luke alone stresses that she is the only daughter, and reports that Jesus allows her parents in the house as he raises her up (8:40-42,49-56). Similarly in 9:38-43, Luke stresses that the afflicted boy is his father's only son, and that Jesus gives him back to his father after the cure. This mirrors the healing of the only son of the widow of Nain, to whom Jesus also gives back the son after the cure (7:12-17). Luke pays particular attention to the social circumstances of the afflicted person, and is especially concerned with the relationships that might be disrupted by illness.

In this healing account, Jesus shows not only an example of mercy in the face of social prejudice and exclusion, but also his complete care for this marginal man, including his concern to restore the disrupted relationships that are essential to human

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[133] Johnson explains that "visit" (episkeptein) is used in the Torah to indicate God's interventions in history (Gen 21:1; 50: 24; Exod 4:31; Ruth 1:6; Ps 105:4 [Septuagint]). Luke uses it in the same sense (Luke 1:78; 7:16; 19:44; Acts 7:23; 15:14). Johnson, *Luke,* 45-6.

[134] Cf. Byrne, *The Hospitality of God.*

life. This cure is a concrete instance of God lifting up the lowly (1:52), gathering the dispersed children of God (13:34), and restoring the community of God's people through Jesus' healing ministry. With the use of the analogical imagination as Spohn suggests, we are called to identify and reach out to the "lepers" and the outcast of our time. The present day HIV/AIDS sufferers readily come to mind, for they are frequently ostracized by the social pressures very similar to what the 'lepers' suffered in Jesus' time. The Catholic network of HIV/AIDS clinics in Vietnam – a topic to be discussed in chapter six – is a good illustration of the Christian outreach to this marginal group, modeled on Jesus' example of mercy and hospitality, and continuing the Christian Church's tradition of care for the poor and the afflicted.[135]

2.5.2. A Woman with a Bent Back Healed – Luke 13:10-17

[10] Now he was teaching in one of the synagogues on the sabbath.[11]And just then there appeared a woman with a spirit that had crippled her for eighteen years. She was bent over and was quite unable to stand up straight.[12]When Jesus saw her, he called her over and said, 'Woman, you are set free from your ailment.'[13]When he laid his hands on her, immediately she stood up straight and began praising God.[14]But the leader of the synagogue, indignant because Jesus had cured on the Sabbath, kept saying to the crowd, 'There are six days on which work ought to be done; come on those days and be cured, and not on the Sabbath day.'[15]But the Lord answered him and said, 'You hypocrites! Does not each of you on the Sabbath untie his ox or his donkey from the manger, and lead it away to give it water?[16]And ought not this woman, a daughter of Abraham whom Satan bound for eighteen long years, be set free from this bondage on the Sabbath day?'[17]When he said this, all his opponents were put to shame; and the entire crowd was rejoicing at all the wonderful things that he was doing.

Context

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[135] See Darrel W. Amundsen & Gary B. Ferngren, 'Virtue and Medicine from Early Christianity through the Sixteenth Century' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (Dordrecht/Boston/ Lancaster: D. Reidel Publishing, 1985), 49-59.

Jesus is on his journey to Jerusalem, and this miracle story, found only in Luke, stands out in the midst of the teaching discourses of Jesus. The last healing story reported by Luke was the exorcism of the mute demoniac, a one-verse account that introduces the controversy about the source and significance of Jesus' power to drive out demons (11:14-23). On that occasion, the analogy is used in which Satan is the strong man guarding his castle and Jesus is the stronger one, who by "the finger of God" defeats Satan and rescues those enslaved by him.[136] In this story, the woman is said to be crippled "by a spirit" which suggests that Jesus' healing intervention is part of the cosmic battle against the forces of evil that cripple and diminish human persons that Luke describes in 11:21-22, and 10:18.[137] This episode also comes immediately after the parable of the barren fig tree, which is part of Jesus' discourse on the need for repentance and timely reform (11:1-12). With the exchange following the cure, the episode identifies the leader of the synagogue and other opponents of Jesus as prime examples of those in need of reform.[138]

Details of the Healing Account

The cure takes place within a synagogue, where Jesus is teaching on a Sabbath. This teaching sets the context for what comes after the cure between Jesus and the antagonist,

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[136] Luke's use of the "finger of God" (cf. Matthew "power of God") is a deliberate allusion to the prophetic power of Moses (cf. Exod 8:19). Johnson, *Luke,* 183.

[137] This story however does not fit the usual pattern of an exorcism story in Luke: there is no word of confrontation or protest by the unclean spirit, no direct command by Jesus to drive out the unclean spirit, no sign of struggle as the spirit is driven out (cf. 4:31-37; 8:26-39; 9:37-43). Note Luke's summary verses 4:40-41, which highlight the combative nature of Jesus' work of exorcism (cf. Mk 1:32-34). Graham Twelftree argues that "for Luke, all sickness has a demonic dimension (is evil), even though it may not be caused by demons" therefore, "in all healing God's adversary is being subdued." Twelftree, *In the Name of Jesus,* 133-134. For that reason, Twelftree classes this story as a healing miracle rather than an exorcism. *Jesus the Miracle Worker*, 296-297.

[138] Fitzmyer, *Luke X-XXIV,* 1011.

who in this case is the leader of the synagogue. Luke depicts Jesus once again using his *power (*cf. 4:14, 36; 5:17) to cure a woman long afflicted with a physical evil.[139] Luke stresses the details of the woman's disability, describing her being "bent over" and "unable to stand up straight." In contrast with the last healing scene, the woman neither approaches Jesus nor petitions for a cure. This provides further clues to the state of her diminishment and loss of agency. It is Jesus who calls her over and cures her by his words, and by laying his hands on her. Luke reports an immediate cure. The woman stands up straight and begins praising God, which signifies the restoration of the woman to her dignity, the renewal of her relationship with God, and the return of her status as a member of the worshiping community.

Bovon notes that Luke uses "the devil" (ὁ διάβολος) seven times (especially in 4:1-13), and "Satan" (ὁ Σατανᾶς) five times in the Gospel (10:18; 11:18; 13:16; 22:3, 31).[140] The two terms are equivalent, and Luke uses them most often in reference to the temptations of Jesus (4:1-13), the evil at work in Judas (22:3) and the "sifting" of the disciples (22:31). However, Luke also presents the devil as the causative agent of many human afflictions and sufferings, as this current account illustrates. The time of Jesus is the period of liberation when the Messiah by the "finger of God" is conquering the devil, stripping his armor, and reclaiming human lives that have fallen into his possession (11:17-22).[141] Yet the victory is not final until the Parousia, and individual persons must

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[139] Ibid.

[140] Bovon, *Luke 1,* 141-2. In Bovon's view, Luke has no developed demonology, and though he is aware of the "supernatural forces that imprison humanity," he knows far more about the liberating power at work in Jesus.

[141] Johnson, *Luke,* 183. Twelftree points out that Luke's deliberate reference to "the finger of God" which mirrors Exodus 3:20, 7:4-5, 8:19 and 15:6-18 is to draw a parallel between the miracles of Moses by which God released Israel from bondage and the miracles of Jesus, by which God released people from the

turn from the power of Satan to the Reign of God (Acts 26:18).

The reaction of the leader of the synagogue illustrates the contrast between Jesus' acceptance of the woman and the dismissive attitude displayed by Jesus' adversaries toward the afflicted woman. The synagogue leader's intervention – venting his discontent on the *crowd* – and the way Jesus responds suggest that the afflicted woman is not a person of status and power, but a lowly person to whom the Lord God is showing mercy. The objection of the synagogue leader demonstrates his failure to see the "finger of God" at work in the cure of the woman which signals the arrival of God's Kingdom (11:20). The objection to this saving act provides a window into the *social* burdens that have weighed down upon this woman and crippled her. Earlier, Jesus has denounced the lawyers for loading people with burdens hard to bear (11:46). Here, Luke's Jesus comes to the defense of this powerless woman by stressing that the welfare of a human being ought to take precedence over the Sabbath obligations (6:1-11).[142] On this occasion Jesus interprets his healing act as a *release* of an afflicted person from the bonds of Satan. His argument is an example of *a minori ad maius* reasoning, arguing from the lighter matter to the more grave.[143] If it is permissible to loose the tether of a domestic animal and lead it to water on the Sabbath, then it is also permissible to loose the bonds of this long suffering woman and restore her to health. Jesus' reference to her as "a daughter of Abraham" places her firmly within God's plan of salvation in fulfillment of the promises

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bondage of Satan. Twelftree also carefully examines the question of the historicity of the exorcism stories from Christian and non-Christian sources and argues that exorcism was very likely a part of the ministry of the historical Jesus. *Jesus the Miracle Worker*, 177-178, 281-292

[142] Fitzmyer, *Luke X-XXIV,* 1011.

[143] Ibid, 1011-1012.

made to Abraham and his descendants (1:54-55).[144] In his depiction of Jesus' ministry, Luke frequently highlights the dignity – perhaps the term *inalienable* dignity is apt here – of marginalized and afflicted persons who are despised by society. The parable of the Lost Son (15:11-32) presents the social outcast as God's lost children, and God as the father who looks at them from afar with compassion and rejoices on their return. In 16:19-31, the poor man Lazarus is taken to Abraham after his death where he receives the consolation that he deserves but never received in this life. In 19:9, Jesus refers to Zacchaeus as a "son of Abraham," stripping away the label and social stigma associated with his occupation, and locating him firmly in the realm of God's mercy. This emphasis on the dignity of persons is characteristic of Luke's depiction of Jesus' healings, and Jesus' outreach to such persons often challenges the flawed perceptions and attitudes frequently found within the community.

Significance for Medical Ethics

The healing of this afflicted woman is a concrete example of God lifting up the lowly (cf. Mary's *Magnificat* 1:46-55), the release of captives from bondage, liberation of the oppressed, and the proclamation of God's acceptance in Jesus' healing ministry (4:18-19). Jesus' healing act reveals his *mercy* toward the woman whom he recognizes as a "daughter of Abraham," thus an heir of God's promise of mercy which is being fulfilled in his person and ministry. The saving intervention begins with Jesus *seeing* the woman, which Luke often associates with *compassion* (ἐσπλαγχνίσθη): Jesus' reaction on seeing the widow of Nain (7:13); the Samaritan on seeing the wounded man (10:33); and the father on seeing the lost son (15:20). Jesus extends hospitality to the woman, restoring

[144] O'Toole, *Luke's Presentation of Jesus: A Christology,* 70.

her to health and to participation in community life, in contrast to the synagogue leader who remains inhospitable to her. This story fits the triangular pattern in Luke, as Byrne identifies, in which Jesus shows the hospitality of God to a lowly or marginalized person who responds to him, and the onlookers who mutter and murmur in discontent.[145] As Byrne points out, the lowly persons and those labeled "public sinners" are often the ones who find God's favor because they are most receptive to it, while the disgruntled onlookers are the ones in need of conversion, for they often resist the restoration of estranged members into the community of God's People.[146] The objection of Jesus' opponents shows their resistance to the liberating work of God: the restoration and gathering of God's children that is taking place right in their sight.

This story particularly illustrates the liberating nature of Jesus' healing acts.[147] Luke's depiction of the woman, who is bent over and unable to stand up straight, is emblematic of many persons, especially women, who are weighed down by social structures that diminish persons and take away their agency. Jesus' intervention liberates the human person from things that hinder personal integrity and health, relationship and participation in community life. His saving acts – both the physical cure and his defense of her against criticism – highlight a particular aspect of healing and health: freedom. This healing account links the theme of liberation in Jesus' inaugural address with his

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[145] Byrne, *The Hospitality of God.*

[146] In the controversy about Jesus and Beelzebul (11:14-23), Jesus warns, "whoever does not gather with me scatters" (11:23), highlighting the battle in which Jesus engages, and one has to take sides either with him or with Satan. The verses on the wandering spirit (11:24-26) also emphasize the need for those who have been liberated from the bondage of Satan to be gathered and protected within the community of the Renewed People of God (cf. Acts 26:18). Johnson, 180-184; Fitzmyer, 916-925; Twelftree, *In the Name of Jesus,* 96-98.

[147] For Tannehill, "release" is a broad category which includes (1) release for the economically poor, (2) release through healing and exorcism (4:31-5:16); (3) "release" of sins (αφεση αμαρτιων). *The Unity of Luke-Acts,* I, 103.

healing ministry. It presents physical affliction as a form of bondage from which persons ought to be released, so as to live with freedom and the dignity of God's children. Jesus' intervention exposes the injustice within human structures, and the way social perceptions and customs can contribute to the bondage and dehumanization of persons.

Again, we are called to identify the various forms of bondage that affect persons of our time. Among them are the various forms of addictions that diminish persons and destroy family relationships: drugs and gambling are among the most serious and destructive. Christian health practitioners are also confronted with the problem of poverty that causes ill health, and the increased risks of contracting HIV among the poor, especially poor women, across the globe. From their work with HIV/AIDS sufferers in Haiti, Paul Farmer M. D. and David Walton assert that "the promotion of social and economic rights for the poor … is the key missing ingredient in the struggle against a pathogen that makes its own preferential option for the poor."[148] They recount unsettling stories of women who, out of economic necessity, enter into risky relationships and then end up with young children and AIDS. Most disturbing among the modern forms of bondage is the trafficking of women and children from poor countries for prostitution purposes.[149] Luke's account of Jesus' healing of the woman with a bent back is a powerful witness to Jesus' solidarity with the downtrodden, and the Christian mandate to

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[148] Paul Farmer and David Walton, "Revealing and Critiquing Inequities: Condoms, Coups, and the Ideology of Prevention: Facing Failure in Rural Haiti" in James Keenan (ed), *Catholic Ethicists on HIV/AIDS Prevention*, (New York/London: Continuum, 2005), 109.

[149] See for instance, Ostrovschi, Nicolae V. ; Prince, Martin J. ; Zimmerman, Cathy ; Hotineanu, Mihai A. ; Gorceag, Lilia T. ; Gorceag, Viorel I. ; Flach, Clare ; Abas, Melanie A. "Women in Post-Trafficking Services in Moldova: Diagnostic Interviews Over Two Time Periods To Assess Returning Women's Mental Health," *BMC Public Health*, April 14, 2011, Vol.11, 232-243; Zimmerman, Cathy ; Hossain, Mazeda ; Watts, Charlotte "Human Trafficking and Health: A Conceptual Model to Inform Policy, Intervention and Research" *Social Science & Medicine,* 2011, Vol.73(2), 327-335.

liberate human persons from forces that enslave and diminish them. The imitation of Christ requires the recognition of the dignity of the poor and afflicted persons and to find practical ways to restore them to the state of living worthy of their true dignity.

2.5.3. Cure of the Blind Man of Jericho – Luke 18:35-43 (Mk 10:46-52/ Mt 20:29-34)

35 As he approached Jericho, a blind man was sitting by the roadside begging.36When he heard a crowd going by, he asked what was happening.37They told him, 'Jesus of Nazareth is passing by.'38Then he shouted, 'Jesus, Son of David, have mercy on me!'39Those who were in front sternly ordered him to be quiet; but he shouted even more loudly, 'Son of David, have mercy on me!' 40Jesus stood still and ordered the man to be brought to him; and when he came near, he asked him,41 'What do you want me to do for you?' He said, 'Lord, let me see again.'42Jesus said to him, 'Receive your sight; your faith has saved you.'43Immediately he regained his sight and followed him, glorifying God; and all the people, when they saw it, praised God.*

Context

This healing is the last of four miracles that Luke depicts on Jesus' journey to Jerusalem. The healing of the blind man follows immediately after Jesus' third prediction of his passion, which the Twelve did not understand, for "what he said was hidden from them" (18:31-34).[150] The gift of sight at this point in the narrative suggests a theological significance, for it prepares the reader to *see* what will shortly unfold in Jerusalem. As Johnson points out, Jerusalem is the center of Luke-Acts, where the Christ of God suffers, dies and rises again. It is also where the disciples are empowered by the Holy Spirit to be Christ's *witnesses* "in Jerusalem, and in all Judea and Samaria and to the ends of the earth" (Acts 1:8).[151]

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[150] Byrne, *The Hospitality of God,* 149-151.

[151] Johnson notes that in Luke's Gospel, the narrative moves *toward* Jerusalem, whereas in Acts, the movement is *outward from* Jerusalem to Judea, Samaria, then Asia Minor and Europe, ending in Rome.

Details of the Healing Account

Luke describes a blind man who sits begging by the side of the road, a lowly and handicapped person at the fringe of society. The story shows Jesus' care for the poor and the afflicted; here by his deed as elsewhere he teaches by his words (16:19-31; 10:25-37, 14:13). The man's calling out for mercy resonates with the cry of the ten lepers in 17:13. His reference to the title "Son of David" echoes the Davidic messianism in the infancy narrative (1:32; 1:69; 2:11), and in the mission speeches to Jewish audience in Acts (2:29-32; 13:22-23).[152] When ordered to be silent, the man is not deterred, but shouts even more loudly, showing the perseverance which Jesus encourages his disciples to have when making petition to God (18:1-8). The man is brought to Jesus and asks to receive his sight again. Jesus promptly grants his request and commends him for his strong faith, "Your faith has saved you." This is the fifth instance in Luke's Gospel in which persons of faith overcome social barriers and find salvation in an encounter with the Lord (cf. 5:20; 7:50, 8:48; 17:19).[153]

After receiving his sight from Jesus' act, the man "followed him" (ἠκολούθει αὐτῷ) (18:43), the same way the first disciples "followed him" (ἠκολούθησαν αὐτῷ) after the miraculous catch of fish (5:11). Earlier in the chapter, references made to "following Jesus" indicate discipleship (18:22, 28). It suggests that the healed man follows Jesus as one of his disciples,[154] and is to be counted among his witnesses in the post-Easter period.

Johnson, *Luke,* 14-15.

[152] In Luke's Gospel, there are further references to Jesus' kingship upon his entry into Jerusalem (19:38), and during the passion narrative (23:35-38). Tannehill, *The Unity of Luke-Acts,* Vol. 1, 274.

[153] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 275. Marshall, *Luke,* 694.

[154] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 275.

On this occasion, Luke reports no murmurs from the bystanders, but "all the people, when they saw it, praised God." The healing of a person of faith becomes "a communal experience of salvation" (cf. 7:16).[155] As Gaiser puts it, Jesus' healing of individuals also serves as "a sign and an invitation of the healing of the community and the world."[156]

Significance for Medical Ethics

At one level, the story illustrates the way Jesus fulfills the messianic hope in giving sight to the blind (4:18, 7:22). The story is linked with the theme of God's mercy toward the poor and the afflicted through Jesus' healing ministry, here in response to the man's plea for mercy. Through his healing act, Jesus lifts up a lowly person and gives him a place among the People of God. Jesus shows hospitality as he receives the man and gives what he asks for. Jesus' hospitable act then allows the community to receive him as its member. The gift of sight begins a new chapter in the poor man's life, for it empowers him to live a normal life, allowing him to move from the margin to the center. It is an experience of salvation, for the Dawn from on high has visited him, giving light to him who sat in darkness, and guiding his feet forward as one among God's People (1:78-79). At this level, the analogical imagination invites Christian disciples to reach out to persons with disability, especially those who live in poverty. The well-documented mutual link between poverty and disability means that many persons across the globe continue to be trapped within the vicious cycle and suffer marginalization; denied access to education, services, employment and recreation; and barred from participation in the life of the

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[155] Byrne, *The Hospitality of God,* 150.

[156] Gaiser, *Healing in the Bible, Theological Insight for Christian Ministry*, 247.

community.[157]

At another spiritual-religious level, the healing narrative helpfully illustrates the way personal healing engenders discipleship.[158] Earlier in this chapter, we examined Spohn's view that stories not only provide the moral resources for the intellect to work out the right choice, but also form persons' affectivity and shape their character.[159] Through the analogical imagination, a Gospel story becomes both a window into the life of Christ and his first disciples, and the mirror that reflects back on our own life of discipleship. Meditating on the stories of Jesus' healings helps guide us to respond appropriately to Christ's invitation.[160] Applying Spohn's model of analogical imagination to the present healing story, we have (i) the paradigm case: "Jesus heals the blind beggar"; (ii) the recognition case: "Jesus heals me"; and (iii) the problem case: "I ought to reach out to the poor and the outcast accordingly."[161] As Spohn sees it, the exercise of analogical imagination is more than an intellectual practice, because the living

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[157] See for instance, Ann Elwan, "Poverty and Disability: A Survey of the Literature" The World Bank: Social Protection, December 1999, at http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2000/12/15/000094946_0011210532099/Rendered/PDF/multi_page.pdf. Accessed May 16, 2012.

[158] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 275.

[159] See also William C. Spohn, 'The Formative Power of Story and the Grace of Indirection' in Patricia Lamoureux and Keven J. O'Neil (eds.), *Seeking Goodness and Beauty: The Use of the Arts in Theological Ethics*, (New York/ Oxford: Rowman & Littlefield, 2005), 13-19. Other theological ethicists also discuss the formative role of the practice of reading Scripture. See Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic*, (Notre Dame, Ind.: University of Notre Dame Press, 1981); also Allen Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids/ Cambridge: Eerdmans, 2003).

[160] William Spohn, *Go and Do Likewise: Jesus and Ethics,* (New York:London, Continuum, 2003), 127-128.

[161] William Spohn, "Jesus and Moral Theology" in James Keating (ed), *Moral Theology: New Directions in Fundamental Issues*, (Mahwah, NJ: Paulist, 2004), 29-30.

Christ is active in our lives, guiding us and inviting our response.[162] In this healing story, Jesus heals the blind man who then follows him. My focus here is on the recognition case: "Jesus heals me, so that I might follow him." This engages a dimension that is indispensable for a theological medical ethics grounded in virtue: the Christian physician's interior life and faith commitment. In seeking to imitate Christ the Good Healer, one must follow him as a disciple. Discipleship in Luke's Gospel begins with the awareness of one's poverty (4:18; 6:20-21; 7:22) and sinfulness (5:8; 31-32; 18:9-14), that is, the awareness of one's need for salvation.[163] While dining with Levi and his friends, Jesus responds to his adversaries' criticism by using a medical metaphor, "Those who are well have no need of a physician, but those who are sick; I have come to call not the righteous but sinners to repentance" (5:31-32). Repentance (μετάνοια), as Tannehill explains, does not consist in mourning and fasting, but a turning of one's life around "through the joyful discovery of a new opportunity," therefore the sign of repentance can be "the joy of finding and being found" (cf. Luke 15).[164] The acknowledgment of one's poverty and sinfulness – the gift of new sight – requires the virtue of humility so as to see oneself among God's poor who stand in need of salvation. This means that, in order to imitate Christ, one needs to be healed and given new sight, to undergo interior transformation by God's grace so as to bring good news and healing to others. To imitate Luke's Jesus is to *see* afflicted persons with compassion, as Jesus saw the widow of Nain (7:13). It is to see the dignity of downtrodden persons as daughters and sons of God who

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[162] Ibid, 31-37.

[163] Byrne, *The Hospitality of God,* 150.

[164] Tannehill, *Luke,* 108.

constantly cares for them (6:35; 12:30, 32). It is to be merciful as God is merciful (6:36).

2.5.4. Healing the Servant of the High Priest – Luke 22:47-53

47 While he was still speaking, suddenly a crowd came, and the one called Judas, one of the twelve, was leading them. He approached Jesus to kiss him;48but Jesus said to him, 'Judas, is it with a kiss that you are betraying the Son of Man?' 49When those who were around him saw what was coming, they asked, 'Lord, should we strike with the sword?' 50Then one of them struck the slave of the high priest and cut off his right ear.51But Jesus said, 'No more of this!' And he touched his ear and healed him.52Then Jesus said to the chief priests, the officers of the temple police, and the elders who had come for him, 'Have you come out with swords and clubs as if I were a bandit?53When I was with you day after day in the temple, you did not lay hands on me. But this is your hour, and the power of darkness!'

Context

The last act in Jesus' healing ministry takes place during his arrest. After the Passover meal, Jesus came with his disciples to the Mount of Olives where he prayed in his intense struggle, and repeatedly urged his disciples to pray before the arrest (22:40-46). Though all four Gospels refer to the cutting of the ear of the chief priest's slave, Jesus' healing act is found only in Luke.[165] This healing gesture most clearly demonstrates Jesus' virtuous character as a healer and a teacher as he faces his own death.

Details of the Healing Account

The healing takes place in the midst of violence and chaos. Judas, his trusted friend betrays him, bringing a band of armed men to the scene, and comes forward to kiss him. The chief priests, the temple police and elders come in the night to seize him by force. His disciples defend him with the sword and slash at the chief priest's slave. Jesus' calmness reveals his inner victory, in the face of the leadership's loss of dignity and

[165] Cf. Mt 26:47-56; Mk 14:43-52; Jn 18:2-12. Johnson, *Luke,* 353.

Judas' betrayal.[166] Jesus yields to the temporal power, but his own power is most clearly seen in the ability to restrain himself, and his disciples, from violent resistance.[167] Most poignant is his healing of the high priest's servant who is clearly an aggressor among his opponents. In this last healing act,[168] Jesus who has taught his followers to "love your enemies, do good to those who hate you" (6:27) is showing a concrete example of this non-discriminatory love in action. Jesus' example highlights the self-sacrificing aspect of the virtue of mercy that Jesus exemplifies. Even in the hour of darkness, Jesus is kind to the wicked and shows mercy to the undeserving, the qualities he has attributed to God in the Sermon on the Plain (6:35-36). This gracious act resonates with Jesus' prayer from the cross on behalf of those who persecute him, "Father, forgive them; for they do not know what they are doing" (23:34).[169] As Johnson puts it, the healing of the servant not only demonstrates that Jesus remains a healer to the end, but also "shows Jesus exemplifying the attitudes of forgiveness and compassion toward those 'who hate him' that he had enjoined on his followers."[170] It is also symbolic of the way God in Jesus deals with human violence, for through Jesus' passion and death forgiveness will come.[171]

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[166] Johnson, *Luke,* 355.

[167] Byrne, *The Hospitality of God,* 176.

[168] Fitzmyer notes that Jesus performs no miracle in Jerusalem or its Temple, and this last healing miracle takes place on the Mount of Olives. *Luke X-XXIV,* 1449.

[169] Though this verse is absent from some significant manuscripts, it is found in other important biblical sources. For a discussion on the textual variations, see Shelly Matthews, "Clemency as Cruelty: Forgiveness and Force in the Dying Prayers of Jesus and Stephen" in *Biblical Interpretation* 17 (2009), 118-146.

[170] Johnson, *Luke,* 353.

[171] Fitzmyer, *Luke X-XXIV,* 1449. Cf. 24:46-48. In line with this, Frederick J. Gaiser holds that Jesus' passion and death is the final and ultimate healing act. Gaiser, *Healing in the Bible : Theological Insight for Christian Ministry* (Grand Rapids, Mich.: Baker Academic, 2010), 224-5.

Relevance for Medical Ethics

If the basic motivating force behind Jesus' healings is mercy, then Luke shows us that his mercy has no bounds. Luke has shown us that Jesus' gift of healing extends beyond ethnic and social boundaries, bringing new life not only to Israelites, but also to non-Jews (8:26-39; 17:12-19), and even member of a centurion's household (7:1-10). With the healing on the Mount of Olives, Luke demonstrates that Jesus' merciful love extends even to his adversaries who are actively seizing him by force. This healing account further highlights the non-discriminatory nature of a Christian medial ethics centered on the imitation of Christ. If we take Drane's virtue of benevolence as the hinge of the medical virtues – or the fundamental attitude of the physician toward the patient – then this benevolence must transcend all socio-political boundaries, and all forms of discrimination if it is to be modeled on Luke's depiction of Jesus the healer.[172]

2.5.5. Healing in Jesus' Name: Cure of a Crippled Man at the Beautiful Gate – Acts 3:1-10

[1]One day Peter and John were going up to the temple at the hour of prayer, at three o'clock in the afternoon. [2]And a man lame from birth was being carried in. People would lay him daily at the gate of the temple called the Beautiful Gate so that he could ask for

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[172] Note the concern with the physician's discrimination of patients expressed in the Codes of Medical Ethics. The Australian Medical Association requires the physician to "refrain from denying treatment to your patient because of a judgment based on discrimination." Similarly, the World Medical Association International Code of Medical Ethics demands that "A physician shall not allow his/her judgment to be influenced by personal profit or unfair discrimination." From the WMA website: http://www.wma.net/en/30publications/10policies/c8/index.html. Accessed January 31, 2011. In contrast, the American Medical Association defends the physician's right to choose patients, "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care." at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page, accessed Feb 15, 2012.

alms from those entering the temple. [3]When he saw Peter and John about to go into the temple, he asked them for alms. [4]Peter looked intently at him, as did John, and said, 'Look at us.' [5]And he fixed his attention on them, expecting to receive something from them.[6] But Peter said, 'I have no silver or gold, but what I have I give you; in the name of Jesus Christ of Nazareth, stand up and walk.' [7]And he took him by the right hand and raised him up; and immediately his feet and ankles were made strong.[8] Jumping up, he stood and began to walk, and he entered the temple with them, walking and leaping and praising God. [9]All the people saw him walking and praising God, [10]and they recognized him as the one who used to sit and ask for alms at the Beautiful Gate of the temple; and they were filled with wonder and amazement at what had happened to him.

Context

After Christ's ascension began the era of the Church, whose task is to continue the salvific mission entrusted to her by Christ (Luke 24:47-48, Acts 1:8). From Luke's perspective, not only is the Church entrusted with the same mission of Jesus, there are also clear parallels between the earthly Jesus and the Church. As Luke sees it, the Holy Spirit who featured significantly during Jesus' infancy narrative (Luke 1:35) is also the divine agent that animates the nascent Church. Just as Jesus was anointed by the Holy Spirit for his mission (Luke 3:21-22, cf. 4:18-19), so are the disciples empowered at Pentecost by the same Spirit for mission. As Jesus came to call sinners to repentance (Luke 5:32), so are the disciples commissioned, as witnesses of the risen Christ, to proclaim "repentance and forgiveness of sins" to all the nations, beginning from Jerusalem (Luke 24:47-49; Acts 1:8).[173] In his account of the healing of the handicapped man at the Beautiful Gate, the author of Luke-Acts presents a direct continuity between

[173] The concept of witness or testimony (*martyria*) emerges in the last chapter of Luke's Gospel then becomes a major motif in Acts (1:8, 22; 2:32; 3:15; 5:32; 7:58; 10:39, 41, 13:31; 22:15, 22; 26:16). Luke Timothy Johnson, *Acts of the Apostles,* Sacra Pagina Series, Vol. 5, Daniel J. Harrington (ed), (Collegeville, MN: The Liturgical Press, 1992), 26. The content of the witness is summarized by Peter at the house of Cornelius, "how God anointed Jesus of Nazareth with the Holy Spirit and with power; how he went about doing good and healing all who were oppressed by the devil, for God was with him" and how "God raised him on the third day and allowed him to appear, not to all the people but to us who were chosen by God as witnesses." (Acts 10: 38-41). Fitzmyer, *Acts,* 1579-1580.

Jesus' healings and the acts of the disciples who heal "in the name of Jesus."

Details of the Healing Account

The healing of the crippled man at the Beautiful Gate by Peter and John illustrates the way the apostles carry on the prophetic role of Jesus in healing and preaching, and become leaders of the restored People of God.[174] The deliberate parallel in linguistic details between this story and Luke 5: 17-26 emphasizes the point that the apostles now have the same healing power as was at work in Jesus.[175] The literary parallelism helps bring out the point that "the apostles are prophetic successors of Jesus."[176] Closely in line with the depiction of Jesus' healings in Luke's Gospel, this healing act by the apostles also brings about the restoration of a handicapped and marginal person to health and full participation in community life. The healing of this lame man (*χωλὸς*) is reminiscent of Jesus' reference to the healing of the lame (*χωλοὶ*) as part of his messianic mission (Luke 7:22, cf. Paul's healing in Acts 14:8-18), and the invitation of the lame among other "outcasts" to the eschatological banquet (Luke 14:21).[177] This handicapped man, once marked by the Torah as "blemished" and sitting at the gate as a beggar, is now leaping through the temple precincts, "praising God," which mirrors Jesus' healing of the woman with bent back (Luke 13:13), and of the blind beggar (Luke 18:43). In addition, "praising God" also echoes Luke's description of the faith community in Acts 2:47. The healing

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[174] Johnson, *Acts*, 71-2.

[175] For instance, the healing command, "rise and walk" echoes Luke 5:23; "began to walk" resonates with Luke 5:25). Johnson, *Acts,* 66-71.

[176] Ibid, 71.

[177] Ibid*,* 64.

by the apostles in Jesus' name again symbolizes the healing and restoration of the People of God (cf. Isa 35:3), and enacts Jesus' mission to "proclaim good news to the poor."[178]

Significance for Medical Ethics

Donald Senior and Carroll Stuhlmueller identify in Luke-Acts a strong biblical foundation for Christian mission to the world today.[179] The evangelist provides the link between Jesus' mission and the Church's mission in Jesus' name. Jesus' commission of the Twelve (Luke 9:1-6) signifies the invitation of Christian disciples through the centuries to participate in Christ's ongoing salvific work in the Holy Spirit, of which healing is an integral part. Luke's emphasis on the social dimension of health and illness highlights the virtues of mercy, compassion, and hospitality in medical practice. In addition, Luke's reference to mission as "to be witness" of Christ suggests that Christian disciples are to be animated by the same Spirit of Christ, so as to proclaim good news to the poor, release to those in bondage, to heal the afflicted and to restore them to relationships in community *as Jesus did* during his earthly ministry. Luke's view of the Church's mission is compatible with the structure of virtue ethics centered on *imitatio Christi* that was discussed in my previous chapter.

Moreover, Gaiser maintains that Christ's commission to proclaim the good news and to heal ought to direct the Church's present-day ministries.[180] For Gaiser, healing must remain part of the Church's proclamation of the saving Gospel of Christ, for it is an

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[178] Ibid.

[179] Donald Senior & Carroll Stuhlmueller, *The Biblical Foundations for Mission* (Maryknoll, New York: Orbis Books, 1983).

[180] Frederick J. Gaiser, *Healing in the Bible: Theological Insight for Christian Ministry* (Grand Rapids, Mich.: Baker Academic, 2010), 223.

integral part of God's gift of salvation. This places the commitment to healing and health firmly in the center of the Church's mission. As Gaiser sees it, the Christian healing ministry involves the cross because Christians are invited to serve the afflicted and to share their suffering with a self-sacrificing love. The call to this greater love also invites action for social transformation. This can involve suffering and sacrifice, but it is always the call to action in hope: the hope in God's future.[181]

2.6. JESUS' HEALINGS - IMPLICATIONS FOR TODAY

The healing narratives in Luke's Gospel present a distinctive view of healing, and of Jesus the Healer that has significant moral implications for Christian health care today. The key insights from this chapter are now recapitulated, and their ethical implications are discussed under three headings: (1) Luke's view of healing; (2) The virtues of Jesus in Luke's healing narratives; and (3) Virtue ethics and the imitation of Christ.

2.6.1. Luke's Holistic View of Health and Healing

Luke presents Jesus' healings through the lens of God's salvific intention for humanity. For this reason, healing belongs within a holistic view of human life, characterized by freedom and relationality. As Gaiser puts it, Luke understands physical cure as part of the renewal of the whole person that occurs through the power of God at work in Jesus.[182] Healing is an integral part of God's gift of salvation that includes: (1) physical and

[181] Ibid, 223-5.

[182] Ibid, 178-190.

spiritual well being; (2) the restoration of relationships with God, with self, and with others in community; and (3) freedom from dehumanizing constraints and controls.[183] The healing narratives examined in this chapter are good illustrations of Luke's emphasis on the social dimension of health and illness. More specifically, in the context of God's mercy and faithfulness to the covenant, Jesus' healing of the deprived and downtrodden persons fulfills God's plan to gather and renew the People of God (13:34, Acts 15:14). This involves the restoration of persons, who have been alienated by diseases and other forms of ritual uncleanness, to life within the community. Through his healing interventions, Jesus *lifts up* human persons from their lowly or marginal status, *restores* their dignity, and *brings* them back to their place of honor among the Renewed People of God. Luke frequently reports that subsequent to Jesus' act of healing, the restored persons praise or glorify God. This religious dimension has a teleological meaning in Luke's view of healing: human persons are to be *healed*, *released* and *restored* so that they can *glorify* God.

In response to God's gift of salvation, persons are called to repentance. Consistent with the social theme in the Gospel, Luke is as much concerned with the conversion of communities as with individual conversions.[184] Jesus' defense of the woman after her cure (Luke 13:10-17) calls for an evaluation of personal attitudes and social structures against God's compassionate mercy (Luke 1:78-79). In addition, God's restoration of downtrodden persons to full participation in the life of the community requires the conversion of the whole community; a conversion that makes the inclusion

[183] Byrne, *The Hospitality of God*, 195.

[184] Ibid, 196.

of such marginalized persons possible. The episodes of the restoration of the 'sinful' woman at the house of Simon the Pharisee (Luke 7:36-50), and of Zacchaeus (Luke 9:1-10) each contains a call to conversion, not of those who are labeled 'sinners,' but of members of the community who mutter and murmur in response to Jesus' gracious act.[185]

Luke repeatedly shows that Jesus' gift of healing extends out to include persons beyond ethnic and social boundaries. Jesus' healing of the high priest's servant at his arrest further illustrates the inclusive and non-discriminatory nature of his mercy. As Gaiser also points out, Jesus' healing of individuals also serves as "a sign and an invitation of the healing of the community and the world."[186] In line with this, Jesus' love command which is illustrated by the parable of the Good Samaritan (Luke 10:30-37) provides an overarching context for a Christian understanding of health care. It is a call to service of the sick out of neighborly love, a love that transcends all socio-political boundaries. It is by giving oneself in loving service of those in physical need that one may inherit eternal life.[187]

Besides the love command, Luke's depiction of Jesus' healings can also inform Christian health ethics in the following ways. First, Jesus' commission of the Twelve, and subsequently of the Seventy, signifies the call of Christian disciples to continue Christ's ongoing salvific work in the Holy Spirit.[188] If Jesus' healings provide a narrative context and texture for a Christian view of health care, Jesus' commission of the disciples links the Church's ministry to the sick with Christ's mission, of which physical healing is

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[185] Ibid., 4-5.

[186] Gaiser, *Healing in the Bible*, 247.

[187] Byrne, *The Hospitality of God*, 100-102.

[188] Senior & Stuhlmueller, *The Biblical Foundations for Mission*.

an integral part. This provides theological context for the Christian virtues of faith, hope and charity in health care. Faith links Christian medical work with Christ's present healing activity through the Spirit. Hope is grounded in the faithfulness of God who continues to visit God's people and redeems them (Luke 1:68). Charity helps bring health services into the realm of God's salvation. Second, Luke's depiction of healings calls for a more holistic view of health care, in which human dignity, freedom, and relationality are taken seriously. Healing in its proper sense requires not only physical cure, but also the restoration of relationships: with self, with God and with others. Third, the gospel of Luke places an emphasis on the social dimension of health and illness, which also is, and ought to be, subject to God's saving activity. In Luke's gospel, Jesus is anointed and sent to proclaim Good News to the poor, liberty to captives, and restoration of sight to the blind (Luke 4:14-30). God's salvific plan does impact upon the social forces that enslave and dehumanize persons. God's saving intention is the restoration of the People of God, which primarily means Israel, but also goes beyond to include the nations. This biblical theological perspective lends support to approaches to health care that take seriously the social determinants of health, such as poverty, exploitation of the poor and the disadvantaged, discrimination and prejudice against persons based on gender, sexual orientation, class, race, culture, and religion.[189] Luke's view also supports a virtue ethic that emphasizes mercy, compassion, and inclusivity.[190]

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[189] See Jonathan M. Mann (ed), *Health and Human Rights: A Reader* (New York : Routledge, 1999); James F. Keenan (ed), *Catholic Ethicists on HIV/AIDS Prevention* (New York/London: Continuum, 2005); Paul Farmer, "An Anthropology of Structural Violence" *Current Anthropology*, Vol.45(3), 2004, 305-325; *Pathologies of Power: Health, Human Rights, and the New War on the Poor,* (Berkeley: University of California Press, 2003).

[190] James F. Keenan, *Commandments of Compassion* (Franklin, Wis.: Sheed & Ward, 1999); *The Works of*

2.6.2. Mercy, Compassion and Hospitality

In this chapter, three virtues have been identified with the character of Luke's Jesus: mercy, compassion, and hospitality. Mercy (ἔλεος) in Luke has its roots in the biblical Hebrew *rakham* and its derivative noun *rakhamim*, adjectives *rakhum* and *rakhamani*. *Rakhamim* in Gen 43:30 and 1Kgs 3:26 indicates an "emotion triggered by afflictions in others" that results in an empathetic bond with the afflicted. [191] For the recipient to accept mercy is to accept the relationship and its requirements, while rejecting mercy is to annul that bond. The divine mercy is initiated by God who has total freedom to show mercy to whom God chooses (Exod 33:19). Mercy, steadfast love (*khesed*), and faithfulness (*'emeth*) are linked with God's covenant with Israel. While mercy is momentary in response to the afflicted, *khesed* (steadfast love) is a constant divine attribute in relation to the covenant (Isa 54:7-8; 63:7). Within this covenant structure, only insiders who keep the ordinances of the Lord can receive God's mercy. Israel's exile occurred because God's mercy was withdrawn (Isa 467:6; 60:10; 63:15; Jer 16:5; 21:7). The postexilic yearning for restoration is often expressed in appeals to God's mercy and steadfast love (Ps 25:6-7, 40, 51). In Zech 7:9-10, God commands the people to show kindness and mercy to one another, especially to the widow, the orphan, the alien, and the poor in imitation of God's mercy.

In the New Testament, three words are used to express mercy or compassion

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Mercy: The Heart of Catholicism, 2nd ed. (Lanham/Boulder: Rowman & Littlefield: 2008); *Virtues for Ordinary Christians* (Kansas City, MO : Sheed & Ward, 1996).

[191] Sze-Kar Wan, "Mercy, Merciful" in *The New Interpreter's Dictionary of the Bible*, Vol. 4, (Nashville: Abingdon Press, 2009), 46-48.

(ἔλεος, ελεεω, ελεήμων). In the Septuagint, ἔλεος is normally used to translate *khesedh* (steadfast love), but also to translate *rakhamim*, *khanan* and *rakham*. In addition, the noun σπλαγχνον (compassion) and the verb σπλαγχνίζομαι (to have compassion) are used frequently in the Septuagint, also to translate *rakhamim*. In Luke's infancy narrative we have seen ἔλεος in reference to the divine mercy shown in God's unfolding plan of salvation (Luke 1:50, 58, 72). The mercy of God in Luke 1:50 recalls God's mercy and steadfast love of Ps 103:4; "remembrance of his mercy" in Luke 1:54 alludes to God's covenantal steadfast love and faithfulness in Ps 98:3; and the covenant to "our ancestors" in Luke 1:72 reminds us of Mic 7:20. Luke also uses ἔλεος to describe the action of the Good Samaritan (Luke 10:37). The cry for mercy "ἐλέησόν" of the ten lepers (Luke 17:13), and of the blind beggar at Jericho (Luke 18:38, 39) echoes the psalmist's plea in Ps 51:1. Jesus' instruction in Luke 6:36 "Be merciful, just as your Father is merciful" [192] resonates with the command in Zech 7:9-10 above. Luke uses σπλαγχνίζομαι (to have compassion) three times in connection with *seeing*: Jesus on seeing the widow of Nain (Luke 7:13), the Good Samaritan on seeing the wounded man (Luke 10:33); and the father on seeing the lost son (Luke 15:20).

Most significant in Luke-Acts is the development in the understanding of God's mercy as the narrative moves from the infancy narrative to Jesus' ministry, then to the Church's mission to non-Jews. The infancy narrative provides the bridge between the Old Testament promises, closely linked with God's covenant relationship with Israel, and the salvific plan that began with the annunciations of the birth of John, and of Jesus. In

[192] Here the adjective οικτίρμων, derived from the noun οικτιρμός, a synonym of ἔλεος is used by Luke for "merciful." This adjective is also commonly used in the Septuagint as an attribute of God.

this context, God's mercy is shown to Israel, in remembrance of the promises made to Abraham and his descendants. This is closely in line with the Old Testament's view of God's mercy and steadfast love, primarily understood within the structure of the covenant relationship with Israel. During Jesus' inaugural address at Nazareth (Luke 4:16-30), his reference to the prophets Elijah and Elisha who reached out and ministered to non-Jews marks a significant step toward an inclusive view of God's mercy.[193] Luke then shows us examples of Jesus reaching out to bring healing to the Samaritan (17:12-19), the Gerasene man (8:26-39), and member of a centurion's household (7:1-10). Most audacious in the teachings of Luke's Jesus is the parable of the Good Samaritan (10:25-37) in which a non-Judean person gives an example of how the love commandment ought to be fulfilled. In Acts, the Church's understanding of God's mercy continues to extend outward with Peter's preaching to the household of Cornelius (10:34-48), followed by the mission to the Greeks in Antioch, and the campaigns of Paul and his companions (Acts 12-13). The good news is proclaimed to despised Samaritans (8:4-13), to the Ethiopian eunuch (8:27-39), and in the cities of Lydda and Joppa (9:32-43).[194] From Luke's perspective, the success of the mission to Gentiles reveals that all people "will be saved through the grace of the Lord Jesus" (15:11).[195]

Though Luke uses ἔλεος and σπλαγχνον (and their derivatives) in different

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[193] Also connected with the understanding of God's mercy in Luke-Acts is the theme of God's love for the sinners, and part of Jesus' ministry is to seek what is lost (5:32; 19:10).

[194] Johnson, *Acts,* 16.

[195] Luke also resists portraying the rejection of the Jews as total or uniform. In the Jerusalem narrative, while the leadership opposes the apostles just as it had Jesus, the ordinary people are shown to convert in great numbers in response to the apostles' preaching (2:41; 4:4). Even with Paul's mission in the Diaspora, Luke shows among Jews not a total but a partial rejection of the gospel, because many Jews and God-fearers do join the Church (13:43, 49; 14:1; 17:4, 11; 19:9). See ibid, 16-18.

contexts, the two words are closely related in meaning and may be understood as synonyms.[196] The English word "mercy," often used to translate ἔλεος, comes from the Latin *misericordia.* In the *Summa Theologiae* Aquinas explains that "mercy takes its name (*misericordia*) from denoting a man's compassionate heart [*miserum cor*] for another's unhappiness" (IIae IIae. q30. a1). Aquinas cites Augustine (De Civ. Dei ix, 5), "mercy is heartfelt sympathy (*compassio*) for another's distress, impelling us to succor him if we can." The Greek noun σπλαγχνα – literally means " bowels," the seat of human emotions in Greek thought – is often translated as "compassion," which itself has its root in Latin *compassio* (to suffer with). Mercy involves a heart felt emotion and an urge to act in response to another's misery. Luke's healing narratives highlight three characteristics of this virtue in Jesus. First, Jesus' mercy is shown most often in his reaching out to afflicted persons who are banished to the margins of society. Jesus' act of mercy extends beyond the bounds of ordinary convention, and challenges Christians to re-examine their own criteria for inclusion/exclusion. Second, Jesus' touching the leper shows his solidarity with the afflicted persons and his willingness to share their suffering. Third, in healing the high priest's servant during his arrest, Jesus shows mercy even to "the wicked," giving an example of the non-discriminatory mercy that is attributed to God (6:35-36). As Keenan puts it, mercy as "the willingness to enter into the chaos of another" best conveys the actions of God "who creates by bringing order out of chaos" and who redeems by lifting humanity out of the chaos of sin.[197] Because mercy involves

[196] Cf. Wan, "Mercy, Merciful" in *The New Interpreter's Dictionary of the Bible*, Vol. 4, 46-48.

[197] Keenan, *The Works of Mercy: The Heart of Catholicism*, 2nd ed., 4- 9.

this solidarity with the afflicted, it may involve suffering for the other's sake.[198]

Hospitality refers to the way Jesus welcomes and cares for those who come to him, regardless of class, gender, social acceptability, or ethnicity. Besides specific accounts of Jesus' healings, Luke's summaries stress that Jesus cures *all* who come to him (4:40-41, 6:17-19). Nevertheless, the distinguishing feature of Jesus' virtue of hospitality is his willingness to receive persons who are despised and cast out from society. Through Jesus' healing acts, the hospitality of God is extended to marginal persons, so that they may be restored and counted among the People of God.[199] If hospitality is characterized as "to make room for the other in our own world,"[200] then Jesus' hospitality to the afflicted persons – like the leper in Luke 5:12-16 – enables society to be hospitable by receiving them back into community. Jesus leads by his examples of hospitality to the outcast, so that others can follow. Note that hospitality in Luke's Gospel is most commonly represented as table fellowship.[201] Even in Jesus' teaching on hospitality, lepers are not included in the list of vulnerable persons to be invited to share at one's table, which includes the poor, the crippled, the lame, and the blind (14:13). In other words, lepers do not ordinarily expect to receive hospitality in people's homes. Instead, Luke presents two accounts of Jesus reaching out to the lepers (5:12-16; 17:12-19), the lowest among the outcast, so that they too can experience the

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[198] Keenan, *Moral Wisdom: Lessons and Texts from the Catholic Tradition,* 72.

[199] Cf. Byrne, *The Hospitality of God.*

[200] Alain Thomasset, "The Virtue of Hospitality: Becoming the Guest of One's Guest" chapter of unpublished book on Scripture and Virtue Ethics, presented at Boston College Ethics Colloquium, April 13, 2012.

[201] Thomasset lists the examples of Jesus in the house of Simon, Jesus in the house of Martha and Mary, the parable of the banquet in 14,1-35; the parable of the prodigal son, Jesus' visit to Zacchaeus the tax collector, the institution of the Eucharist and the Emmaus event.

knowledge of salvation (1:77).

Keenan identifies mercy as the defining virtue of early Christianity, when Christians gave of their resources, sometimes putting their own lives at risk, to help immigrants and the sick in crowded Greco-Roman cities.[202] As historians Amundsen and Ferngren see it, Christianity from its conception has perceived the duty to care for the poor and the sick as an indispensable part of its mission.[203] During the times of epidemics, the Christian zeal to care for the suffering was most evident, and contributed significantly to the rise of Christianity. The Christian practice of hospitality is also linked with the care for the sick, and the formation of health care facilities. By the early Middle Ages, monasteries had became places of refuge for the destitute, and religious men and women were deeply involved in the provision of medical care for the sick in hospitals. Medical charity was widely considered an integral part of the monastic movement that was blossoming in this period. This zeal to serve the sick poor was essentially taken over by the mendicant orders beginning in the thirteenth century.

In the words of Henry Sigerist, Christianity played a vital role in determining the way in which the sick are cared for,

> Christianity came into the world as the religion of healing, as the joyful Gospel of the Redeemer and of Redemption. It addressed itself to the disinherited, to the sick and afflicted, and promised them healing, a restoration both spiritual and physical… It became the duty of the Christian to attend to the sick and poor of the community… the social position of the sick man thus became fundamentally different from what it had been before. He assumed a preferential position which has been his ever since.[204]

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[202] Keenan, *The Works of Mercy,* 4-5.

[203] Darrel W. Amundsen & Gary B. Ferngren, 'Virtue and Medicine from Early Christianity through the Sixteenth Century' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (Dordrecht/Boston/ Lancaster: D. Reidel Publishing, 1985), 49-59.

[204] Sigerist, H. E. *Civilization and Disease,* (Ithaca: Cornell University Press, 1943), 69-70. Quoted in

Mercy and hospitality are not only the outstanding virtues of Jesus the Healer in Luke, they were also the defining virtues of early Christianity and of early Christian health ethics. In response to the mercy of God who reaches out to us, and in imitation of Christ who calls us to follow him, we practice mercy.[205]

2.6.3. The Imitation of Christ and the Interior Transformation

The virtues of mercy and hospitality, through the lens of Luke's healing accounts (in the context of the Hebrew tradition), have distinctive content and textures compared to the Greco-Roman virtues *philanthropia*, *praotes*, and *epiekeia* that Cotter identifies.[206] Beavis stresses the counter-cultural nature of Luke's introduction of the Hebrew tradition of care for the poor and the outcast to Greco-Roman converts.[207] Greco-Roman upper classes generally despised people of the lower class, whom they called *humiliores*, and to give to the poor without expecting some personal gain is something quite foreign to them.[208] Luke's writings thus provide a critique of his contemporary cultural values, and a witness to an alternative way of life in light of, and transformed by the good news of Christ.

The imitation of Christ, from Luke's perspective, ought to be centered on Christ's partiality toward the poor, in light of his interventions on behalf of the lowly and the

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ibid., 50.

[205] Keenan, *The Works of Mercy,* 9.

[206] As Cotter explains, the full definition of *philanthropia* in Greco-Roman antiquity is provided by Hubert Martin Jr, "affability, courtesy, liberality, kindness, clemency, … The philanthropos is gracious and considerate towards all with whom he associates, he is generous towards the needy, he is also merciful and clement towards his enemies." Hubert Martin Jr, "The Concept of Philanthropia in Plutarch's Lives," in *AJP* 82 (1961): 164-75, cited in Cotter, *Christ of the Miracle Stories,* 10.

[207] Mary Ann Beavis, ""Expecting Nothing in Return": Luke's Picture of the Marginalized," 364-5.

[208] Philip Esler, *Community and Gospel in Luke-Acts,* 171, 198.

outcast. The healing of the crippled beggar at the Beautiful Gate is both an illustration of the way Jesus' examples of mercy and hospitality are imitated by the apostles Peter and John, and a witness to the continuation of Christ's healing works in the ministry of his disciples through the Spirit. In other words, there are two levels by which Christian disciples become conformed to the pattern of Christ: the ethical level and the theological-spiritual level. At the ethical level, Christian formation is understood in terms of identifying the virtues found in the Gospels, here through Luke's healing accounts, and how to cultivate these virtues through choices and practices within the faith community. From a Christian virtue ethics approach, Christ is the normative goal of Christian life, and the basis of Christian practice for the cultivation of virtues. More specifically, Christian health practitioners are called to engage in the liberation of poor and afflicted persons, so as to bear witness to the liberating power of the gospel of Christ. At another level, the theological vision in Luke-Acts connects present-day disciples with the life and mission of Jesus through the Holy Spirit. In line with the general structure of virtue ethics, but not confined by it, Luke presents Christian life as a process of interior transformation by the Holy Spirit into the pattern of Christ. As Johnson puts it,

> Like Paul, Luke saw the work of the Holy Spirit as the replication in the lives of believers of the messianic pattern enacted first by Jesus (see 1 Cor 2:16; Phil 2:5, Gal 6:2). Luke communicates his conviction through a narrative …that the working of God's Spirit in human freedom did not cease with Jesus but continued in the lives of the disciples. Luke's account of Pentecost (Acts 2:1-42) is therefore not only an artistic success, but also the creation of a narrative connection between the work of God in Jesus and in believers.[209]

This brings a theological dimension to the motif of imitation of Christ. At this theological level, however, the primary agent is the Holy Spirit who is constantly at work

[209] Johnson, *Acts,* 1.

within believers through faith, transforming them according to "the messianic pattern" of Jesus. In addition, because Luke understands the Holy Spirit as the prophetic Spirit derived from the Risen Lord (Acts 2:17-21, 33), the author of Luke-Acts is able to link Jesus and his disciples in a *prophetic succession* as was the case of Moses and Joshua (Deut 34:9); or Elijah and Elisha (2 Kgs 9-14).[210] The interior transformation by the Holy Spirit emboldens Christians to proclaim the Good News through words and deeds, and prepares them to accept the suffering that may be involved in the works of mercy and hospitality.

2.7. CONCLUSION

The author of Luke-Acts presents a very rich and attractive portrait of Jesus through the healing accounts. These illustrations of the character of Jesus the healer therefore have significant implications for a virtue-based medical ethics centered on the *imitation of Christ*. The evangelist presents Jesus' healings in the light of a distinctive theological lens that highlights the virtues of mercy and hospitality in Jesus. These virtues, which are connected with two key themes in Luke-Acts, have their origin in the Old Testament and refer primarily to God's saving action toward humanity. In parallel with the evolving theme of universality in Luke-Acts, there is also an expanding view of God's mercy and hospitality through the ministry of Jesus, and of the Church. Through this narrative structure of Luke-Acts and through his depiction of the role of the Holy Spirit, the evangelist stresses that the Church's mission is in fact a *continuation* of Jesus' earthly

[210] Ibid, 14.

ministry. I believe that this continuation occurs at both the ethical level and the theological-spiritual level, both of which are significant for a virtue ethics centered on the imitation of Christ. At the ethical level, the evangelist presents an exemplary pattern in Jesus' healings, which is replicated in the disciples' healing acts in the post-Easter era. At a deeper theological level, Luke presents Christian disciples being transformed interiorly by the Holy Spirit into the pattern of Jesus, so as to engage in the same mission of Jesus. Luke's theological perspective also makes Christian ethics part of the salvation history, precisely because Christian formation and praxis are oriented toward the *continuation* on earth of the presence and ministry of Jesus Christ.

Chapter III: THE VIRTUOUS PHYSICIAN FROM AN EAST ASIAN PERSPECTIVE: VIRTUE IN THE MEDICAL TEXTS OF HẢI THƯỢNG LÃN ÔNG

3.1. INTRODUCTION

Having examined some virtue-based approaches to medicine in the Euro-American context and studied the way virtue ethics can provide the ethical hermeneutical key for the integration of the gospel vision into present-day medical practice, this study now looks at virtue-based medicine from a Vietnamese Confucian perspective. The chapter examines some key texts from Lãn Ông's medical compendium *Hải Thượng Y Tông Tâm Lĩnh*, [The Theory and Practice of Hải Thượng School of Medicine] within their historical context. Lãn Ông's work is chosen for a number of reasons. First, Hải Thượng Lãn Ông (1724-1791)[1] is one of the most prominent Vietnamese physicians of all time and the pioneer of Vietnamese medical ethics. To date, his medical compendium, which consists of twenty eight books that detail the theory and practice of Eastern medicine, has remained the most complete and influential work in this field by a Vietnamese author. This monumental work begins with a series of moral precepts, *Y*

[1] Hải Thượng Lãn Ông (referenced as Lãn Ông in this chapter) is the cognomen of Lê Hữu Trác. Within the Vietnamese tradition, it is respectful to refer to the person by the cognomen rather than by the birth name. This cognomen literally means 'lazy man of Hải Thượng,' expressing his lack of political ambition. This self description is significant in a society that sought to appoint learned scholars to public office. The term 'Hải Thượng' combines the names of Hải Dương Province and Thượng Hồng District where he came from. Hải Thượng Lãn Ông, *Hải Thượng Y Tông Tâm Lĩnh,* 4 Vol., translators and editors: Nguyễn Văn Bách, Nguyễn Minh Cầu, Lê Bá Cơ, Nguyễn Khắc Dụ, Nguyễn Thành Giản, Nguyễn Hữu Hách, Nguyễn Văn Hạp, Phạm Văn Liễn, Chu Văn Liễn, Lê Đức Long, Đinh Văn Mông, Nguyễn Ngọc Oanh, Nhữ Hồng Phấn, Vũ Xuân Sung, Phó Đức Thảo, Nguyễn Đăng Thập, Tô Văn Thiện, Nguyễn Đình Tích, Ngô Quý Tiếp, Nguyễn Văn Tố, Nguyễn Hữu Triệu, Lê Trần Đức, Nguyễn Trung Hòa, Phạm Văn Lãm, Nguyễn Quang Quỳnh, Nguyễn Duy Tấn, Nguyễn Tử Siêu, (Hà Nội: Nxb Y Học, 2008), Vol. 1, 5.

Huấn Cách Ngôn [Moral Precepts for Physicians] which have left enormous influence not only on Vietnamese traditional medicine but also on Vietnamese medical ethics until the present. [2] Second, Lãn Ông's medical ethics is representative of the Confucianist tradition which has greatly shaped the Vietnamese culture through the centuries. His work is grounded in a long academic tradition that continues to partly define the cultural identity of today's Vietnam. For this reason, the study of his ethics provides valuable insights into the cultural context within which the gospel message is received. If ethical hermeneutics is essential for bringing the moral insights from biblical texts into present-day practice, knowledge of the values and aspirations within the hearers' context is also important for the inculturation of the gospel message. Lãn Ông's medical ethics, centered around "humaneness" the defining virtue of medicine, also offers opportunities for cross-cultural dialogue.[3]

This chapter demonstrates that Lãn Ông's *Moral Precepts for Physicians* both reiterates earlier moral guidelines in Chinese medical literature and develops them further in a distinctive direction. His frequent emphasis on the physician's competence and moral character represents a sustained attempt to uphold the fiduciary nature of the healing art. In addition, Lãn Ông's particular concern for the poor highlights the social

[2] That Lãn Ông has a primary place in Vietnamese medical ethics is illustrated by the fact that his moral teachings, including his *Moral Precepts for Physicians* (Y Huấn Cách Ngôn) appear in most textbooks on traditional medicine by Vietnamese authors, for instance Nguyễn Trung Hòa, *Đông Y Toàn Tập* [Eastern Medicine: A Compendium] (Hue, Thuan Hoa Publisher, 2000); Trần Ngọc Quý, *Y Học Cổ Truyền – Đông Y* [Traditional Medicine] Trường Đại Học Y Hà Nội, Bộ Môn Y Học Cổ Truyền Dân Tộc, (Hanoi, Nhà Xuất Bản Y Học, 2008). Lãn Ông's ethics was a major subject for discussion at a recent conference on biomedical ethics organized by the Medical University of Hanoi, the proceedings of which were published under the title, *Đạo Đức Y Học* (Hanoi: Nhà Xuất Bản Y Học, 2011). The 1996 Code of Medical Ethics of Vietnam (12 Điều Y Đức-Tiêu Chuẩn Đạo Đức của Người Làm Công Tác Y Tê) promulgated by the Ministry of Health (Document No. 20881BYT-QĐ) on November 6, 1996 also shows the influence of Lãn Ông's ethics in the articulation of the medical profession and the physician's duties.

[3] Lãn Ông's view of "humaneness" shares interesting similarities with the love command in the Luke's Gospel and also differs significantly from it. This is the topic of the following chapter.

responsibility of physicians, whom he defines as "guardians of human lives." This study begins with an overview of the historical context of Lãn Ông's work, then provides a close reading of the *Moral Precepts for Physicians* against the background of Chinese medical tradition and Confucian learning, and discusses Lãn Ông's medical ethics with reference to other key texts from Lãn Ông's corpus.

3.2. VIETNAM IN THE EIGHTEENTH CENTURY

3.2.1. The War Between North and South – The Two Lords

The eighteenth century was the time of civil war between the two lords during the Later Lê Dynasty:[4] the Trịnh in the North and the Nguyễn in the South. The Lê dynasty became weakened since Mạc Đăng Dung usurped the throne in 1527. In 1532, Nguyễn Kim and his son-in-law Trịnh Kiểm, who remained loyal to the Lê dynasty, defeated the Mạc and restored a descendant of the Lê to the throne.[5] After the death of his father-in-law, Trịnh Kiểm and his sons assumed political power in the Lê's domain, while the Lê king had only a ceremonial function. Nguyễn Hoàng, the younger son of Nguyễn Kim, fled to the southern district of Thuận Hóa in 1558 for fear of Trịnh Kiểm. In 1599, Trịnh

[4] The Later Lê (Hậu Lê) is distinguished from the Early Lê dynasty (Tiền Lê: 980-1009). In 1428, after leading the ten year struggle for independence from the Ming occupation, Lê Lợi became king, founding the Lê dynasty, which lasted until 1788, the longest reigning dynasty of Vietnam. There were important social, agricultural and educational reforms that took place during this era, as well as the southward expansion of the kingdom that resulted in the annexation of the Hindu kingdom of Champa (1697) and six provinces of Cambodia (1708 and 1759) into Vietnam. See Trần Trọng Kim, *Việt Nam Sử Lược* [A Brief History of Vietnam], vol. 2. (original 1921; reprinted Ho Chi Minh City: NXB TP Ho Chi Minh, 2000), 20-51; Peter C. Phan, *Mission and Catechesis: Alexandre de Rhodes and Inculturation in Seventeenth-Century Vietnam* (Maryknoll, New York: Orbis Book, 1998), 4-8.

[5] The Mạc lost its support base in the capital, established itself in the Northen provinces of the kingdom. Throughout its reign, the Mạc constantly engaged in armed conflict with the Lê, until it was defeated and lost its throne in 1592. The descendants of the Mạc withdrew to the Northenmost Province of Cao Bằng, where they survived until 1667.

Tùng, who succeeded his father Trịnh Kiểm, appointed himself the Trịnh Lord. In the meantime, Nguyễn Hoàng (1502-1613) and subsequently his son Nguyễn Phúc Nguyên successfully built up their own domain in the South. Nguyễn Phúc Nguyên, who ruled from 1613 to 1635, declared independence from the Trịnh and became the first of the Nguyễn Lords who ruled the South. Thus began the civil war between the two lords. Between 1627 and 1672, the Trịnh tried to invade the Nguyễn's territory seven times without success.[6] In 1672, both sides agreed to a ceasefire, taking the Gianh River as the dividing line. From the early seventeenth century until the late eighteenth century, the country known to the West as Annam was divided into Tonkin in the north (Đàng Ngoài) which was ruled by the Trịnh Lord under the dominion of the Lê King, and Cochinchina in the south (Đàng Trong) which was under the Nguyễn Lord.[7] The decades of civil war resulted in countless number of casualties on both sides.[8] The high taxes required to pay for military expenses and the loss of the labor force exhausted the strength of the nation,

[6] Trần Trọng Kim, *Việt Nam Sử Lược* [A Brief History of Vietnam], vol. 2, 31-51. The Trịnh Nguyễn conflict continued into the late eighteenth century, when the Nguyễn was defeated by the Tây Sơn brothers in 1783. The Tây Sơn subsequently advanced Northward and defeated the Trịnh in 1786. The Tây Sơn king Quang Trung subsequently defeated the Qīng invasion in 1789 and unified the kingdom. After Quang Trung's death in 1792, Nguyễn Ánh, a descendant of the Nguyễn lords, overthrew the Tây Sơn and became emperor Gia Long ruling the unified kingdom in 1802. The Nguyễn dynasty lasted until August 25, 1945 with the abdication of the last Emperor Bảo Đại.

[7] The name Tonkin (Viet: Đông Kinh) was the former name of the capital Thăng Long (today: Hanoi). The name Cochinchina has its root Cochin derived from Giao Chỉ, the ancient name of Vietnam, and the suffix –china to differentiate it from Cochin in India. See Peter Phan, *Mission and Catechesis,* 6-7. During the French rule, Vietnam was divided into three parts (by the June 6, 1884 treaty): Tonkin, Annam, and Cochinchine (North, Central and South Regions of Vietnam). Cochinchina in the seventeenth and eighteenth century was very different from Cochinechine of the nineteenth century under French Rule.

[8] For instance, in the 1627 the Trịnh Lord mobilized the total of 200, 000 soldiers in his conquest of the Nguyễn domain. In 1672, the Trịnh commanded the total of 100, 000 soldiers in the final campaign against the South.

and worsened the poverty of the population.[9]

In Tonkin, Lãn Ông's region, the period of stability after the 1672 peace accord allowed significant developments in agriculture and commerce.[10] In education, there were regular state examinations every three years from 1678 onward.[11] Confucianism gradually became the dominant ideology, and Confucian scholarship continued to flourish during the Lê-Trịnh era. The compilation of important history books, works of literature, and encyclopedic volumes took place during this period.[12] The establishment of local printing shops allowed the natives to reduce the demands of printed materials imported from China. The printing craft also facilitated the publication of medical texts during this era, including texts from native authors, such as the texts of the fourteenth century Buddhist monk and physician Tuệ Tĩnh.

However, there was growing social and political unrest in Tonkin in the first decades of the eighteenth century, due to the widening gap between the landless peasants

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[9] Cf. Antoine Bui Kim Phong, "Evangelization Of Culture And Inculturation Of Faith Alexandre De Rhodes, S.J. (1593-1660) And His Mission In Việt Nam" Dissertazione per il Dottorato Dipartimento Di Storia Della Chiesa, Rome: Pontificia Università Gregoriana 2011, 70-72.

[10] Quoc Anh Tran, "*Tam Giáo Chư Vọng* [The Errors Of The Three Religions]*:* A Textual And Analytical Study Of A Christian Document On The Practices Of The Three Religious Traditions In Eighteenth-Century Vietnam" PhD Dissertation, Theology Department. (Washington D.C.: Georgetown University, 2011), Chapter 1, 17-19.

[11] Though abuses also arose within the examination system. In 1750, for lack funds, the government allowed those who could pay a set fee to sit the state exams without going through the preliminary examination process. This opened the door to many abuses that resulted in the loss of credibility of the examination system. Phạm Văn Sơn, *Việt Sử Toàn Thư,* 398.

[12] History books: Đại Việt Sử Ký Bản Kỷ Tục Biên (1675) by Phạm Công Trứ and others; Quốc Sử Thực Lục (1676) by Hồ Sĩ Dương, Lê Hy and Nguyễn Quý Đức; Quốc Sử Tân Biên (1775) by Nguyễn Hoàn, Lê Quý Đôn, Ngô Thời Sĩ, Nguyễn Du; Đại Việt Thông Sử (1749) by Lê Quý Đôn. In literature: Tục Truyền Kỳ by Đoàn Thị Điểm; Chinh Phụ Ngâm by Đặng Trần Côn (Chinese script) and Đoàn Thị Điểm (in Viet script), the works of Lê Quý Đôn: Quần Thư Khảo Biện, Thánh Mô Hiền Phạm Lục, Toàn Việt Thi Tập, Vân Đài Loại Ngữ, Kiến Văn Tiểu Lục, Quế Đường Thi Tập, Quế Đường Văn Tập. See Dương Quảng Hàm, *Việt Nam Văn Học Sử Yếu*, 614-617; Phạm Văn Sơn, *Việt Sử Toàn Thư,* 349.

and the land owners. There were droughts and floods that resulted in loss of crops and widespread famine in Tonkin between 1727 and 1730. The high taxation, costly imperial building projects, and corrupt rulers led to mounting dissatisfaction among all segments of the population. Numerous rural uprisings against the Trịnh occurred in the 1730s and continued into the 1760s.[13] All rebellions were harshly suppressed by the Trịnh Lords, who remained in power until their defeat by the Tây Sơn in 1786. This was the context of Lãn Ông's decision to discontinue his military career, and to show little interest in public office.

3.2.2. Indigenous Religious Practices, Buddhism, and Daoism

Similar to the first century Greco-Roman world, many health related beliefs and practices in eighteenth century Vietnam were connected with the religious beliefs of the natives. A detailed account of the Vietnamese religions of this era is well beyond the scope of this study. Nevertheless, my brief overview aims to provide some background to Lãn Ông's texts and help inform the reader of some of the presuppositions within his socio-cultural context. My focus remains on the connection between religious beliefs and the health practices of Vietnam prior to the radical transformations that came with the French domination in the late nineteenth century.

A crucial characteristic of traditional Vietnamese religions was the tendency to harmonize diverse religious beliefs and practices. Vietnamese people had the ability to integrate newer religious traditions into the existing belief systems without seeing them

[13] Phạm Văn Sơn, *Việt Sử Toàn Thư,* 350-51. Cf. Quoc Anh Tran, "*Tam Giáo Chư Vọng"* Ch 1, 20.

as contradictory.[14] They freely took elements from different religious traditions and incorporated them into their own religious practices and worship. As the French missionary and anthropologist Léopold Cadiere pointed out, the indigenous religion of the Viet people was the cult of spirits.[15] The people venerated elements of the natural world, such as the sun, moon, mountains, rocks and trees, as well as the spirits of deceased ancestors, heroes and venerables. This indigenous form of animism was the foundation on which Confucianist ethics, the Buddhist view of the afterlife, and the Daoist practices where integrated.[16]

Buddhism came to Vietnam during the Chinese Later Han period (25-220) to become a major influence in the religious as well as the socio-political life of Vietnam. By the tenth century, the veneration of native deities and heroes in Buddhist temples was common. Buddhism reached its peak during the Lý dynasty (1010-1225) and continued to flourish during the Trần dynasty (1225-1400) to become one of the three main religio-philosophical systems in Vietnam. The Lý and Trần kings were patrons of Buddhism, but adopted the policy of openness and toleration toward other religious traditions. Many prominent Buddhist monks, by far the most educated persons in the state, became national advisors and had significant political influence. Buddhism suffered decline during the Hồ dynasty (1400-1407), the Ming domination (1407-28) and the Later Lê dynasty (1428-1788). King Lê Thái Tổ, founder of the Later Lê dynasty, enforced Confucian doctrines in the country, while forbidding construction of new pagodas,

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[14] Quoc Anh Tran, "Tam Giáo Chư Vọng," ch 1, 25.

[15] Léopold Cadière, *Croyances et pratiques religieuses des Viêtnamiens,* 3 vols, (Hanoi: 1944-1956; reprint: Paris: École Française d'Extrême-Orient, 1992), vol I: 6.

[16] Tran, "Tam Giáo Chư Vọng", 25-26.

restricted subsidies to monasteries, and required Buddhist monks to pass examinations on Buddhist canons in order to remain in the monastery.[17]

Daoism (or Taoism, Đạo giáo) came to Vietnam also during the Later Han era, between the second and third centuries.[18] It is important to distinguish between philosophical Daoism and religious Daoism. Philosophical Daoism is a system of thought based on the classics *Dao De Jing* of Lao Tzu, and *Nan Hua Jing* of *Chuang Tzu* which provides a worldview based on the concepts of *Dao* and *De*. Upon this worldview is derived a political philosophy which emphasizes the attitude of *wu wei* (無為, vô vi) often translated as "noncontrivance" or "non-activity."[19] The interchange between the philosophical Daoist worldview and Confucianist rationality gave rise to Chinese cosmology during the Song dynasty. There were discourses on the substance (*qì* 氣, Viet: khí), the nature (*hsing*, 性, Viet: tính) and the principle (*li* 理; Viet: lý) of the

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[17] Phan, *Mission and Catechesis,* 14-15. Professor Nguyễn Đăng Thục attributes the moral and political decline during the reign of the subsequent kings of the Lê dynasty to the decision to make Confucianism the sole guiding ideology of the state, to the exclusion of Buddhist and Daoist beliefs. In his view, because Confucianist ideology supported the centralization of power in the hands of the ruler, it led to the alienation of the common people on one hand, and the abuse of power by the ruler on the other. Under the rule of the tyrant king Lê Uy Mục (1505-1509) who massacred twenty six of his own relatives to protect his throne, and king Lê Tương Dực (1510-1515) who killed eighteenth of his relatives, civil unrest and rebellions took place. This eventually led to the usurpation of the throne by Mạc Đăng Dung in 1530. While it is clear that Confucianism became the ideology of the state, and that there was moral and political decline in early sixteenth-century Vietnam, the causal link between these two facts is hard to prove. See Nguyễn Đăng Thục, *Lịch Sử Tư Tưởng Việt Nam,* [The History of Vietnamese Thought] Vol. VI-VII, Nguyễn Trãi với Khủng Hoảng Ý Thức Hệ Lê-Nguyễn (1380-1442) (Original: Saigon: Bộ Văn Hóa, 1967 - Reprinted Hochiminh city: NXB TP Hochiminh, 1992), 52-60.

[18] In this study, I use Pinyin Romanization of most Chinese words, except for some proper names that are commonly used in English such as Confucius, Mencius, Lao Tzu, and Chuang Tzu.

[19] Fung Yu-lan, *A History of Chinese Philosophy*, vol. I, 183-7. Nguyễn Hiến Lê, *Lão Tử Đạo Đức Kinh,* 123-145. It is important to note that "non-activity," properly understood, does not mean lack of action, but it means to act in accordance with the *Tao*, so that "non-acting" can lead to "nothing that is not done" 無不為 (*wu pu wei*). In the Preface to the *Cases Resulting in Death* (Y Âm Án), Lãn Ông argued from the Confucianist ethical perspective against the attitudes of complacency and fatism that have their roots in the Daoist ethics of "non-activity."

universe in the works of Zhang Zai, Cheng Hao, Cheng Yi and Zhu Xi.[20] Philosophical Daoism also explains *Dao* and *De* in terms of the yin-yang theory, which is the subject of the Confucian Classic *I Ching*. The *Yin-Yang* theory, the theory of *Five Elements*, and the doctrine of the *Unity of Man with Nature* which were enriched by the exchange between philosophical Daoism and Confucianism became the foundation of Eastern medicine,[21] and reflected in Lãn Ông's work. Generally speaking, philosophical Daoism did not have much influence in Vietnam outside of the Literati circles.

Religious Daoism (Viet: Đạo giáo), on the other hand, is a religion with a very complex origin that came to prominence with the Yellow Turban movement during the Later Han era.[22] By the tenth century, Daoism was well established in Vietnam, along with Buddhism and Confucianism. Under the patronage of the Lý and Trần kings, Daoist temples were built for the worship of the Jade Emperor (Ngọc Hoàng) and the Daoist pantheon. Religious Daoism, with its practice of magic, alchemy, divination and geomancy, was well received by the Viet population because it was compatible with the indigenous religious mentality. Apart from the Daoist recluses who sought longevity or

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[20] Ibid, 476-571. The Wade-Giles forms of these scholars are Chang Tsai, Cheng Hao, Cheng Yi and Chu Hsi.

[21] The *Yin-Yang* theory and the theory of *Five Elements* are significant topics in the works of Tung Chung-Shu (179?-105? BCE) of the Chinese Former Han era. The doctrine of the *Unity of Man with Heaven* was articulated much later, in the works of Chang Tsai and the Cheng brothers of the Sung dynasty (960-1279). Fung Yu-lan, *A History of Chinese Philosophy*, vol. II, 7-54; 477-571. Giản Chi & Nguyễn Hiến Lê, *Đại Cương Triết Học Trung Quốc*, vol I, 115-116.

[22] According to Nguyễn Ước the connection between religious Daoism and philosophical Daoism is rather complex. Religious Daoism has its roots in (i) the Chinese cults of spirits, the use of amulets and charms… that began in the ancient Chou era; (ii) the search for longevity and immortality during the Ch'in dynasty; (iii) the philosophy of Lao Tzu that emphasizes detachment and purity of lifestyle. For this reason, the Yellow Turban movement elevated Lao Tzu to the status of The Great Founder King (Thái Thượng Lão Quân) and attributed to him the invention of its mystical technique. Nguyễn Ước, *Đạo Học Đại Cương,* Tủ Sách Dũng Lạc, 2011. Henri Maspero, *Taoism and Chinese Religion,* tr. Frank A. Kierman, Jr. (Amherst, The University of Massachussetts Press, 1981), 25-31.

immortality through physical and mental exercises, there were Daoist 'masters' (thầy) who performed cultic healing rituals or magic for those who sought their assistance. *Thầy bùa* (master of the amulets) would create the amulets by writing on pieces of paper which are either worn or consumed by the patient to ward off the bad forces which were believed to cause ill health. *Thầy pháp* or *thầy cúng* (magician-healer) would perform a number of rituals to expell or apease the bad spirits that brought illness or misfortunes. *Thầy bói* (diviner) would predict the outcome of the patient's illness in advance. *Thầy địa lý* (geomancer) would give advice on *feng shui* in regard to building, and place of burial for the dead. Furthermore, Vietnamese Daoists also used the mediums (đồng nhân) to communicate with persons of the spirit world.[23] Though Vietnamese Daoism did not take the institutional form as in China, it remained a significant religion among the populace, with many superstitious elements.[24] The concept of retribution that permeates much of the Chinese medical tradition – and reflected in Lãn Ông's writings – likely has its roots in the Daoist doctrine of *cheng-fu* 承負[transmission of burden] which teaches that the good or evil deeds performed by the ancestors have consequences on the destiny of the descendants.[25] What is characteristic of Lãn Ông's view of retribution – which is in line with the Chinese understanding – is the strong support for human action. Actions that benefit others are believed to bring rewards to oneself and/or one's

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[23] Nguyễn Duy Hinh, *Người Việt Nam với Đạo Giáo* (Hanoi: NXB Khoa Học Xã Hội, 2003), 353-81. Quoc Anh Tran, "Tam Giáo Chư Vọng," 35-39.

[24] Certain beliefs and practices of these types contitnue to this day among Vietnamese people.

[25] Though Tao Lee thinks that this view of retribution likely has its roots in the Buddhist doctrine of Karma, Kenneth K. S. Ch'en argues that it is quite distinct from it, because the Buddhist doctrine teaches that the consequences of one's deeds are experienced by one's later reincarnation, not by one's descendants. Tao Lee, "Medical Ethics in Ancient China" 137-8. Kenneth K. S. Ch'en, *Buddhism in China: A Historical Survey,* (Princeton NJ: Princeton University Press, 1964), 48-52.

descendants; immoral actions are believed to bring misfortunes to the perpetrators and/or their descendants.

3.2.3. Confucianism in Vietnam[26]

Kŏng jiào (孔教, Confucianism) came to Vietnam during the first Chinese occupation (111 BCE to 39 CE). In the first century of the Common Era, Han Chinese Governors Tích Quang and Nhâm Diên sought to educate the natives in Chinese script and Confucian learning. However, the early attempts to bring "civilization" to the Viet natives were met with resistance, partly due to the vigor of the native culture and language, partly due to the pro-independence sentiments among the natives.[27] After a short period of independence, which was won through the inspiring leadership of the Trưng sisters, began the second period of Chinese occupation (43 – 544 CE). Governor Sĩ Nhiếp (187-226), a learned scholar and a good administrator, was able to promote learning among the Việt natives. Confucian scholarship of this era was notably

[26] There are several distinctive concepts behind the English word *Confucianism*. Broadly speaking, Confucianism, known in Chinese as *Kŏng jiào* (孔教, Vietnamese: Khổng giáo) is a philosophical, social, ethical and religious system based on the teachings of Confucius and his successors. Kŏng jiào is more commonly known as *Rú jiào* (儒教, Nho giáo) once it has been established in a state. *Rú* (儒) which literally means a scholar, is identified with the Confucianist scholar and Confucianist scholarship, the most common form of scholarship in East Asian context. *Rú jiā* (儒家) refers to scholars of the *Rú* school. The learning of the *Rú* school is called *Rú xué* (儒學, Viet: Nho học), with its own principles and methodology which began with Confucius, and adopted by later scholars and masters. Some recent authors use "Ru" and "Ruism" instead of "Confucian" and "Confucianism." See Robert Eno, *The Confucian Creation of Heaven: Philosophy and the Defense of Ritual Mastery* (Albany: State University of New York Press, 1990); Lionel M. Jensen, *Manufacturing Confucianism: Chinese Traditions and Universal Civilization* (Durham and London: Duke University Press, 1997); Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy* (New York: Cambridge University Press, 2007). In this study, "Confucian" is used for things pertaining to Confucius, while "Confucianist" is used to render *Rú* (儒) or *Rú xué* (儒學).

[27] Trần Nghĩa, "Thử Bàn về Thời Điểm Du Nhập cùng Tính Chất, Vai Trò của Nho Học Việt Nam Thời Bắc Thuộc" [On the Introduction of Confucianism to Vietnam and Its Role During the Chinese Occupation] in *Nho Giáo ở Việt Nam* [Confucianism in Vietnam] (Hanoi: NXB Khoa Học Xã Hội, 2006), 82-87.

influenced by the interpretation of Han philosopher Dong Zhongshu, who introduced metaphysical elements into classical Confucianism, and especially stressed the "union between heaven and man."[28] For his promotion of learning, Sĩ Nhiếp was regarded as "Nam Giao Học Tổ" [pioneer of Viet learning] by the Việt scholars. However, ambivalence toward Confucianism remained among the Việt natives until the end of Chinese domination, in 939 CE when Ngô Quyền overthrew the Chinese rulers and began the era of independence for Vietnam.

During the occupation period, Confucianism was perceived by many as the ideology of the oppressors, and a means of governance by the foreign rulers. Not until the period of independence did the Viet fully embrace Confucianism. In 1070, Emperor Lý Thánh-Tông built the Literati Temple (Văn Miếu) for the worship of Zhou Gong, Confucius, the Four Masters and Seventy Two Sages, and sent the crown prince to study there.[29] Confucianist schools were established to form scholars in learning and virtue, who can then serve the state. Professor Trần Văn Đoàn of the National University of Taiwan believes that there was a political reason why Viet scholars of this period faithfully followed Confucianist scholarship of China. Though independence had been won, the superior military force of the Northern Kingdom remained a constant threat, thus the best strategy for the Viet rulers – and the Viet scholars who provided guidance to

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[28] Van Doan Tran, "Confucianism: Vietnam" in Antonio S. Cua (ed), *Encyclopedia of Chinese Philosophy*, (New York/London: Routledge, 2003), 173.

[29] *Khâm Định Việt Sử Thông Giám Cương Mục* [A Royal Commissioned History of Viet], Vol. 1, (original 1881, trans 1960, reprinted Hanoi: Nxb Giáo Dục, 1998), 345. The common understanding is that the Lý Emperor *built* the Temple in 1070, which served as both a place of worship and a teaching institution. However, Nguyễn Tài Thư argues, from a close reading of Đại Việt Sử Ký Toàn Thư [A Complete History of Viet], that the Emperor *repaired* the Temple in 1070, which implies that it had been built prior to that year, perhaps in the 8th or 9th century during the Chinese occupation. This argument is interesting but not convincing. See Nguyễn Tài Thư, "Nho Học Việt Nam Đầu Độc Lập và Thời Điểm Thành Lập Văn Miếu ở Thăng Long" in *Confucianism in Vietnam*, 93-100.

them – was to be flexible and non-confrontational.[30] The Viet scholars of this era embraced Chinese Confucianist scholarship of the Song dynasty (*Sòng rú* 宋儒: Tống Nho) whose focus was *lixue* (理學: lý học): the study of *reason* or *principle* behind matter. The Cheng brothers (Cheng Hao and Cheng Yi), Zhu Xi, and Wang Yangming, who were influential thinkers of the Chinese Song and Ming dynasties, became major authors for study in Viet schools. Because of the prominent place of the Cheng brothers in Vietnamese scholarship, the phrase "cửa Khổng sân Trình" [the gate of Kung and the courtyard of Cheng] was used to refer to teaching institutions in Vietnam.

In Trần's view, after the initial phase of resistance, there were two phases in the development of Vietnamese Confucianism (Việt Nho). The first was the "first fusion" phase in which Vietnamese scholars selected elements from Confucianist scholarship of the Song and Ming dynasties, *qi* (氣, khí: energy), *ren* (仁, nhân: benevolence), *li* (理, lý: principle), *tianli* (天理, thiên lý: heavenly principle), and *lǐ* (礼, lễ: rites) to construct "a practical philosophy" for civil life and for governance. The characteristic of Vietnamese scholarship of this period was the mixing of the rationalist and pragmatic elements of Confucianism with Buddhist and Daoist doctrines. This conscious movement was grounded in the conviction that all three religious philosophies share the same *root* (tam giáo đồng nguyên), the belief itself derived from Chinese thought (三教同元, *sān jiào tóng yuán*). The works of Viet scholars Chu Văn An, Nguyễn Trãi (1380-1442), Lương Thế Vinh (1441-?), and Nguyễn Bỉnh Khiêm (1491-1585) reflect both the pragmatism of Confucianism and the metaphysical elements of Daoism and Buddhism.

[30] Van Doan Tran, "Confucianism: Vietnam," 174.

During the second phase, Confucianism became the mainstream in Vietnam, reaching its pinnacle in the late sixteenth century during the Later Lê dynasty, then suffering a sharp decline from the mid nineteenth century under French domination. This era of Viet Confucianism is characterized as "the second fusion," in which Viet scholars sought to integrate Confucianist norms into social, cultural and political life. The Viet ethos, which includes fortitude in the face of hardship and pragmatism, was harmonized with the Confucianist virtues of benevolence, loyalty, and filial piety to give rise to an integrated moral system, which was formalized in moral codes and civil laws. The clearest example of this is the law code Quốc Triều Hình Luật (or Luật Hồng Đức) promulgated during the reign of Emperor Lê Thánh Tông (1460-1497). The comprehensive moral and legal codes developed at this time aimed to cultivate the Viet ethos *and* Confucianist virtues (understood to be entirely compatible with each other) in the citizens through social structures such as the family, the social organizations, and the education system. As before, the metaphysical elements of Buddhism and Daoism were not neglected, for they were also incorporated into the system of thought that supports these moral norms. This fusion transformed Confucianism from a political philosophy into a religious philosophical system (*Rú jiào* 儒教, Nho giáo) with a very significant pragmatic dimension.

3.2.4. Selecting Scholars for Public Office - The State Examinations

Once Confucianism became the mainstream within society, those eligible for public office had to be Confucianist scholars. Periodically, state examinations were held to select learned scholars for appointment to public office. From Lãn Ông's writings, it is

clear that during his youth he was educated for the state examinations in pursuit of a career in public office. This examination system has shaped the education system of Vietnam from the eleventh century onward, and through it has shaped the entire ethos of the Viet people.[31] In 1075, King Lý Nhân Tôn held the first state examinations to select learned scholars for public office.[32] These were the first examinations given by Vietnamese rulers. During the Lý dynasty (1009-1225), examinations were also held in 1086, 1152, 1165, 1185, and 1193. In 1195, King Lý Cao Tôn gave examinations on the Three Religions (thi Tam Giáo): Confucianism, Buddhism, and Daoism. During the Trần dynasty (1225-1400), examinations took place on a regular basis at two levels: the province (thi hương), and the capital (thi hội). Again, Buddhism was highly esteemed during the Trần dynasty, and in 1247, King Trần Thái Tôn also gave examinations on the Three Religions. In the seventeenth century, during the Lê dynasty, examinations took place at three levels on a regular basis: the province (thi hương), the capital (thi hội), and at the imperial court (thi đình), a month after *thi hội*.[33] The ordinary subject of study was the Chinese classics: the Five *Jing* (ngũ kinh) and Four *Shu* (tứ thư).[34] Examinations at all three levels took four days, the first day on the Chinese Classics (ngày kinh), the second day the composition of poetry (ngày lục), the third day prose composition (ngày phú), and the fourth day a philosophical or political or historical essay (ngày sách). At

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[31] Phan, *Mission and Catechisis,* 22-23.

[32] Dương Quảng Hàm, *Việt Nam Văn Học Sử Yếu* [A Brief History of Vietnamese Literature] (original 1943, reprinted Hanoi: NXB Trẻ, 2005), 117.

[33] Phan, *Mission and Catechesis,* 23.

[34] The Five Classics include: *Book of Poetry, Book of Rites, Book of History* (*Spring and Autumn Annals*) and *Book of Change* (*I-Ching*). The Four Books include: *The Analects of Confucius, The Great Learning, The Doctrine of the Mean*, and *Mencius*. Some commentaries on these Classics by Chinese and Vietnamese authors also became part of the academic tradition and thus examinable.

the province level, successful candidates after three days of examination were awarded the degree of *sinh đồ*, later changed to *tú tài* (bachelor). After the fourth day, successful candidates were given the degree of *hương cống*, later changed to *cử nhân* (licentiate). Candidates who succeeded in the four tests at the capital level were awarded the degree of *tiến sĩ* (doctorate). A month later, the new doctors sat for the examination at the imperial palace, presided over by the king himself. Successful candidates are awarded honors according to six categories, in descending order of honor: (1) *trạng nguyên*, (2) *bảng nhãn*, (3) *thám hoa*, (4) *hoàng giáp*, (5) *chính tiến sĩ*, and (6) *đồng tiến sĩ*. Holders of degrees enjoyed considerable benefits and priviledges: exemption from military service and from paying taxes, opportunities for public office at the district level (for holders of the licentiate) and at the national level (for holders of the doctorate). The higher degrees were awarded only sparingly due to the limited number of public offices available.[35]

Because of the great honors associated with academic degrees, generations of young men would undergo vigorous academic training in pursuit of a career in public office. Once they had achieved academic degrees and public office, they were able to put their learning and skills to the service of the state, at the same time bringing honor and prosperity to themselves and their families. In his foreword to one collection of clinical cases *Y Âm Án* [Cases that Resulted in Death], Lãn Ông wrote in reference to his background and aspiration,

> It is only because I failed to attain public office [through academic path], not able to continue the family tradition, I have turned to medicine, aspiring to do all that I could,

[35] Phan, *Mission and Catechesis,* 23-25.

> so as to avoid shame when facing heaven and earth, not concerned with honor and recognition, but simply to avoid regrets in my duties. When I was young, I left the academia for a medical career, spending ten years studying day and night, training in medical skills, aiming only to help others. In dealing with the wealthy, [I have] not allowed myself to be influenced by the desire for personal gains; in dealing with the poor, [I have] not allowed myself to be careless in matters of life and death.[36]

Lãn Ông's background in Confucianist learning, his ethos and methodology would place him with the group of scholarly physicians known as *Rú-i* (儒醫, nho y) or *Confucianist physician* within the Chinese medical tradition.

It is important to note that the education program of Vietnam which followed the Chinese model, focused largely on literature, philosophy, statecraft, and morality. As a general rule, it did not provide the practical knowledge on commerce and the ordinary crafts, such as agriculture, construction or mining.[37] Instead, practical skills were gained through apprenticeship with the artisans. In particular, there were no schools to train physicians in pre-modern Vietnam. Those who aspired to become physicians would normally follow a practicing physician and study under his guidance. Many physicians passed their craft onto their children, and would often keep the secrets of the craft within the family.

3.3. THE BACKGROUND OF THE MORAL PRECEPTS FOR PHYSICIANS

3.3.1. The Author – Hải Thượng Lãn Ông

Hải Thượng Lãn Ông, birth name Lê Hữu Trác, was born on December 11, 1720, at Văn

[36] Hải Thượng Lãn Ông, Preface to "Y Âm Án" [Cases that Resulted in Death] in *Hải Thượng Y Tông Tâm Lĩnh*, 442.

[37] Antoine Bui Kim Phong, "Evangelization Of Culture And Inculturation Of Faith," 73.

Xá Village, Đường Hào District, Thượng Hồng Prefecture, Hải Dương Province.[38] He was from a family of famed scholars. His paternal grandfather Lê Hữu Danh, father Lê Hữu Mưu, and brother Lê Hữu Kiển earned doctorate degrees from the state examinations and were appointed to public office. Lãn Ông himself was introduced early into the academic tradition. After his father's death in 1739, he continued with his study for some time, but did not succeed at the state examination. He left academia and joined the army of the Trịnh Lord in 1740, where he showed good military leadership skills. When his brother Lê Hữu Chân died, leaving three young children, he sought discharge from military service, despite offers of promotion, so as to support both his elderly mother Bùi Thị Thưởng and his brother's family.

In 1746, Lãn Ông came to settle in his mother's home town of Bầu Thượng, Tỉnh Diệm, where he remained until his death in 1791. It is noteworthy that soon after his discharge from military service, he fell seriously ill, and the experience of the long illness led him eventually to a new career path. After several years of treatment with no improvement, he went to Rú Thành, Nghệ An Province, and was treated by the physician Trần Độc in 1749. The period of treatment was more than a year, and during this time he began to study medical texts, with the help of his physician Trần Độc. Once the treatment was over, he continued to collect medical texts for private study at home, with the help of another physician in a nearby village. After several years of study, he began his work as a physician. In 1754, he went to the Imperial City to acquire more medical

[38] For the biography of the author, see Phó Đức Thảo, Introduction to *Hải Thượng Y Tông Tâm Lĩnh*, 5-6; cf. Lãn Ông's own narrative in his Preface to the compendium, 19-23. See also Nguyễn Văn Thang, *Hải Thượng Lãn Ông: Nhà Y Học Lớn, Nhà Văn Hóa Lớn* (1724-1791) (Hanoi: Nxb Văn Hóa Thông Tin, 2001).

texts for further study. He soon became a famed physician in Hoan Châu Province.

In 1760, Lãn Ông began writing his own medical texts and took apprentices. In 1782, the Trịnh Lord summoned him to the Imperial City to treat the Crown Prince Trịnh Cán. Though his remedies proved effective, he was not confident of complete success, partly because of the complexity of the illness, and partly because of the jealousy of the court physicians. Uncomfortable with the tense atmosphere at the Royal City, he asked for release from duty and returned home.[39] Until his death in 1791, he continued to compile and amend his medical compendium, "Y Tông Tâm Lĩnh," and also wrote "Thượng Kinh Ký Sự" [Journey to the Imperial City] which later became an added chapter of his "Y Tông Tâm Lĩnh."

3.3.2. Literary Influence – Traditional Chinese Medicine

Lãn Ông's text *Moral Precepts* shows notable influence from the medical texts and moral teachings of the Chinese medical tradition. Sinologist and historian Paul Unschuld, in his thorough study of medical ethics in ancient China, identifies and translates most of the significant texts on Chinese ethics, many of which come in the first section of ancient manuscripts on medicine, indicating their importance to the authors.[40] Lãn Ông's *Moral*

[39] Soon after he went home, he received news that Hoàng Đình Bảo, who assisted him during his time at the Royal City had been killed, because of his connection with Đặng Thị Huệ faction.

[40] Unschuld interprets all developments in the entire history of Traditional Chinese Medicine through a "hermeneutic of social control," in which the major players engaged in an ongoing struggle for resources and benefits. I think this sweeping conclusion is unsubstantiated. Another shortcoming in Unschuld's work is the assumption that as a rule, Confucians were against all forms of specialization. Unschuld's view is based on a restricted understanding of Confucius' phrase: *Jūn zǐ bù qì* 君子不器 "the scholar is not an instrument" (*Analects* 2.12) , (p. 21), and he interprets all the historical events and texts in light of this foregone conclusion. For example, on page 17, Unschuld describes a process of "deprofessionalization" in order to strip the professional group of the power of their resources. On page 36, he maintains that Lu Chih was against the practice of medicine as a profession, which I think is a misreading of the text. Lastly,

Precepts also comes in the first section of his medical compendium *Hải Thượng Y Tông Tâm Lĩnh,* and its content reflects the major concerns and teachings of this tradition. It is apparent that Lãn Ông saw himself as part of this medical tradition and wrote medical texts in order to pass on his learning and experience as a practicing physician. For this reason, Lãn Ông's text must be interpreted in light of earlier writings in the Chinese medical tradition.

Though traditional Chinese medicine has a history that extends for several centuries before the common era, Sun Szu-miao (581?-682) appears to be the first Chinese author to present a structured approach to medical ethics.[41] Though usually referred to as a Daoist, Sun Szu-miao seems to be equally influenced by Buddhist thought and informed by Confucianism. [42] In his major work, *Pei-chi ch'ien-chin yao-fang* (Bí kíp thiên kim yếu phương), Sun Szu-miao wrote a section on the virtues of the Great Physician *Lun Ta-i Ching-Chéng* [On the Absolute Sincerity of the Great Physician], in which he stressed the importance of physician competence, the attitude of compassion toward every living creature, and the physician's duty to treat all patients equally, regardless of their status,

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Unschuld's reference to the struggle for power between the Daoist medical practitioners and the Confucianist physicians is problematic. It is more accurate to refer to the former group as "yin-yang magicians" whose practice was somewhat related to Lao Tzu's writings. For instance, on page 36, Unschuld wrote, "In his [Lu Chih] conclusion he makes a very obvious critique of the Taoists' involvement in alchemy and magic. Sun Szu-miao was in fact numbered among those so involved." It is important to note that there was significant exchange between Confucianism and Daoism (and also Buddhism). Much of Confucianist cosmology, especially from the Song dynasty (960-1279) onward, was shaped by Lao Tzu's writings, which then became part of the world view of Confucianist scholars *and* Confucianist physicians down the centuries. Paul Unschuld, *Medical Ethics in Ancient China: A Study in Historical Anthropology*, (Berkeley/ Los Angeles/ London: University of California Press, 1979).

[41] Unschuld uses the Wade-Giles method of Romanization, which I retain in this section to make it easy for the reader to make reference back to Unschuld's original text. For Pinyin forms and Chinese ideograms of these names, terms and phrases, see the glossary included in this chapter.

[42] Ibid, 25.

wealth, age, appearance, enemy or friend, native or foreigner, educated or uneducated.[43] A great physician would "look upon the misery of the patient as if it were his own" and work hard to relieve suffering, disregarding inconveniences such as dangerous roads, night-call, bad weather, hunger and fatigue.[44] A physician ought to refrain from boasting of himself or slander against other physicians. Sun Szu-miao attributes this saying to Lao-Tzu, "Open acts of kindness will be rewarded by man while secret acts of evil will be punished by God."[45] He also warns against prescribing expensive and rare medications for patients simply because of their wealth or of high rank, in order to boast about it, because such conduct is contrary to the teaching of *humaneness* (*chung-shu*: 忠恕). This reference to *chung-shu*, a major moral teaching that goes back to Confucius himself (*the Analects* VI, 15; VI, 28; XII, 2), demonstrates the influence of Confucianism on the author's ethics. Sun Szu-miao's influence on subsequent authors is immense. A number of issues that he raised later became major themes in Chinese medical ethics: physician competence, sincerity, compassion, equal regard for the rich and the poor, empathy with patients, and retribution for malpractice.

The first Confucian scholar to write on medical ethics is Lu Chih (754-805 CE), who earned a *chin-shih* [doctorate] at the age of eighteen, and held a number of administrative positions before his admission to the *Han-lin* academy, where he became an intimate friend and adviser of the emperor. Lu Chih was the first to refer to medicine as *practiced humaneness* (仁術, *ren-shu*), and advised physicians to act with humaneness and

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[43] Ibid, 30-31.

[44] Cf. Tao Lee, "Medical Ethics in Ancient China," in Robert Veatch (ed) *Cross Cultural Perspectives in Medical Ethics*, 132-133.

[45] Tao Lee's translation. See ibid.

compassion toward patients. He also censured physicians who took advantage of the needs of patients, deceitful and greedy in their conduct, thus unworthy of the art of *humaneness*. Similar to Sun Szu-miao, Lu Chih points to the long term consequences of physician behavior,

> Nowadays it can frequently be observed that the descendants of [good] physicians accumulate luxury, live in happiness and in splendor and are elected to the higher ranks. In the last instance this is yet another expression of a reward through heavenly principles. What need is there then to plan only for the profit which arises from an occasion and to then be considered a thief? [46]

Chang Kao (fl. 1210 CE), author of the medical compendium *I-shuo*, was well known for his eruditeness, and his application of Confucian scholarly method in the compilation of the writings of earlier physicians in order to make them known to his own time. For this he was considered a Confucianist physician (*rú-i*: 儒醫, nho y) by Chiang Ch'ou, his contemporary, because he "manifests the disposition of a true man of letters," thus distinguished himself from common physicians (*yung-i*:庸醫, dung y).[47] In a chapter in this medical compendium, *I-kung pao-ying* [Retributions for medical practice], Chang Kao related twelve stories as examples of good versus bad practice and the consequences of each. In one story, the scholar Hsu devoted himself to the study of medicine, and served others regardless of high or low rank. He then succeeded in the state examinations for the title of *chin-shih* [doctorate]. In another story, the physician who resisted sexual favors from a former patient was rewarded with long life, and academic success among his children and grandchildren. This collection of anecdotes also reveals the widespread

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[46] Lu Chih, *Lu Hsuan kung lun*, in Hsu Ch'un-fu, *Ku-chin i-t'ung ta-chu'uan*, ch. 3b, pp. 13a-13b, translated and cited in Unschuld, *Medical Ethics in Imperial China*, 36.

[47] Ibid, 42.

use of fraudulent methods by physicians, whom the author considered to be no different from armed bandits.[48]

Chu Hui-ming (ca 1590 CE), a Confucianist scholar who turned to medicine, wrote in *Tou-chen ch'uan-hsin lu*, that medical learning is a noble path, and principles of medicine are difficult to attain. For that reason, practitioners of this art must not be negligent, but strive for what is right and noble. He also insisted that a physician ought to regard other people as himself, and to consider it a physician's duty to assist others. If a physician acts out of self-interest, the virtue of humaneness will be violated.[49] He cited the ancient saying, "There are no two kinds of drugs for the lofty and the common; the poor and the rich receive the same medicine," and insisted on equal care for the poor and the rich. Again, his writings reveal that behaviors contrary to the teachings were common: physicians speaking deceptively, filled with envy and self-interest, exploiting patients in their illness, demanding copious presents. These physicians seemed to value material goods but had little regard for human life. The author also denounced the tendency to keep useful medical books secret for one's private ends, rather than sharing the knowledge with others. He warned that misfortune would visit such corrupt physicians in their own person and in their descendants.

Kung Hsin (ca 1600 CE) was a Confucianist physician who worked in the imperial office of medicine (*t'ai-i yuan*). He distinguished between the enlightened physicians *ming-i*, the term closely coincides with *rú-i* (Confucianist physicians), and

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[48] Ibid, 47, cf. Tao Lee, "Medical Ethics in Ancient China," 133-134.

[49] Unschuld, 60.

common physicians (yung-i).[50] He discouraged patient solicitation, which was commonly done by emphasizing one's skills above others in the same professional group. He insisted that enlightened physicians ought to cultivate humaneness and righteousness in their attitude, and their mercy ought to resemble the mercy of Heaven and Earth. At the same time, their learning ought to be broad and comprehensive in both theory and its practical use. In his view, the enlightened physicians ought to prescribe medicines appropriate for each disease, and the drug combinations are to correspond with patient symptoms. Enlightened physicians would seek the best course of treatment, and do not adhere rigidly to any formula. On the other hand, he warned against the unethical behavior of common physicians (yung-i) who often boasted about the unusual cases that they had cured in order to solicit patients. Common physicians often neglected the study of the classical texts, and practiced with a very poor knowledge of medicine, not able to make distinction between subtle forms of illness. If the disease turned worse, they would disappear quickly, for they were only concerned about profit, not for the patient.[51] It is apparent that various professional groups of physicians existed at this time, and competition among them was present. Kung Hsin's directive against patient solicitation at the expense of fellow physicians indicates the group awareness, and the protection of its members' interests. Receiving remuneration for medical services was acceptable. However, ideal physicians would be motivated by humaneness rather than by profit.

Kung T'ing-hsien (fl. 1615 CE), son of KungHsin, also worked in the imperial office for medicine, following his father's example. In the ethics section in *Wan-ping*

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[50] Kung Hsin, *Ku-chin t'u-shu chi-Cheng*, text translated in Unschuld, *Medical Ethics in Imperial China*, 68-69.

[51] Ibid, 70.

hui-ch'un, he wrote ten maxims for physicians and ten maxims for patients. In the *Ten Maxims for Physicians*, he maintained that physicians ought to cultivate "a disposition of humaneness" and to make special efforts to assist people through good deeds. In his view, physicians ought to "master the Confucianist teachings," because he regarded Confucianist physicians as a precious help at all times by virtue of their learning and principled conduct.[52] Physicians ought to pay attention to the preparation of drugs: the intensity of the fire in the boiling of drugs, how fine the medicinal herbs be cut, and to know the right quantities. He also warned physicians against jealousy, for physicians ought not to be guided by people's favor or disfavor. Finally, physicians "should not esteem profits too highly, but instead cultivate humaneness and righteousness."[53] Again, he reiterated the old saying that there was but one type of medicine, for both the poor and the rich.

Chen Shih-kung (陳實功,fl. 1605 CE), whose writings show the clearest influence on Lãn Ông, agreed with the ethical directives of earlier Confucianist physicians. Similar to earlier authors, he wrote with the aim of raising the value of medical practice. He seems to belong to the group of physicians who practiced for profit but considered themselves Confucianist physicians. Chen did not maintain the distinction between the elite group and other "second rate" physicians, but referred only to physicians. In the ethics section of his book *An Orthodox Manual of Surgery* (外科正宗 ,Wai-k'o cheng-tsung), he wrote the *Five Commandments for Physicians* (醫家五戒) and the *Ten Requirements for Physicians* (醫家十要) that reiterated many directives of earlier

[52] Ibid, 71.

[53] Ibid, 72.

Confucianist physician authors. There are several new elements in Chen Shih-kung's ethics: his advice on how physicians ought to treat patients who are prostitutes, and advice on financial investments for physicians. His warning against criticizing one's colleagues in front of patients, and his advice on courtesy toward fellow physicians both seem to reflect the group consciousness similar to Kung T'ing-hsien, who also presented the ten maxims for physicians.[54] Because of their influence on Lãn Ông's *Moral Precepts for Physicians* (醫訓格言), Chen Shih-kung's original Chinese texts and their translation are provided in the appendix section of this chapter, along with Lãn Ông's text and its translation for comparison.

This overview of the history of Chinese medical ethics shows the development of a number of key themes that began with Sun Szu-miao: physician competence, humaneness in patient care, equal regard for the rich and the poor, empathy with patients, and the view about reward and retribution for physician conduct. In addition, with the Confucianist physicians, great emphasis was put on the knowledge of *Rú lĭ* (儒理, Nho lý) or the principles of Confucianism, for the medical sciences were derived from Confucianist learning *Rú xué* (儒學, Nho học). In line with Sun Szu-miao's emphasis on

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[54] Ibid, 76-77. The writings of Chang Lu (1627-1707 CE), a Confucianist scholar who studied medicine after the fall of the Ming dynasty, give us a window into medical practice in China immediately preceding Lãn Ông's time, under the early Manchurian rule (Ch'ing dynasty, 1644-1911). In 1695, he wrote *Chang-shih i-t'ung*, a book on general medicine, with the ten commandments for physicians, giving a strong critique of behaviors indicative of the decline in Confucianist moral standards among practitioners of this era. In his view, the learned Confucia scholar ought to keep a respectable distance from the mediocre physicians who display their skills publicly and boast about their competence in order to gain fame and fortune, abasing both the standards of behavior *and* the learning of Confucianist scholarship during this socio-political climate.

Unschuld believes these ten warnings represent the "most vehement attacks against professional physicians from the point of view of orthodox Confucianism." I believe this is a misreading of Chang Lu's text. Unschuld, *Medical Ethics in Imperial China*, 85-86.

the physician virtue of humaneness (仁, *ren*), Confucianist physician-scholars defined medicine as "practiced humaneness" (仁術, *ren-shu,* nhân thuật), thus making *humaneness* an integral part of the medical art. The Confucianist physicians, beginning with Lu Chih, also referred to the kind of immoral behaviors that are unworthy of "practiced humaneness," which reflects the underlying concept of the rectification of names (正名, chính danh), that is central to Confucianist ethics.

There is also a significant development toward greater specification of what is morally required of the physician. The earlier authors highlighted the physician virtues: sincerity
(*chéng* 誠), humaneness, compassion, and empathy. There were also moral norms to be observed: to treat the rich and the poor equally, to work hard to relieve patient suffering, and to disregard personal inconveniences while serving patients. With Kung T'ing-hsien's *Ten Maxims for Physicians*, then Chen Shih-kung's *Five Commandments* and *Ten Requirements*, there was a greater degree of specification of the values and norms expected of the physician. These later formulations became increasingly similar in form to the modern codes of medical ethics.

3.3.3. Traditional Medicine in Vietnam

Little is known of the health practices in ancient Vietnam prior to the era of Chinese domination. During the Chinese rule (111 BCE - 931 CE), the Viet natives continued to maintain and develop their own branch of traditional medicine, though considerable exchange with Chinese medicine took place. After independence was won, from the Lý

dynasty (1010-1225) onward, the imperial medical institute, known at this time as *Ty Thái Y*, was established to serve the health needs of the royal family and the manderins. There were also trained physicians who provided medical services for people in villages. During the Trần dynasty (1225-1400) the imperial medical institute was renamed as *Viện Thái Y*. Phạm Công Bản was a royal court physician of the Trần dynasty, who one day delayed his response to the king's summon in order to care for a peasant woman with after birth complications. He was commended by the king for this good act.[55] Nguyễn Bá Tĩnh (religious name: Tuệ Tĩnh), a Buddhist monk, scholar and renowned physician of the fourteenth century, was the first Vietnamese author to write manuscripts on Vietnamese traditional medicine. He was raised in a Buddhist monastery, became a learned scholar, and passed the state examinations for the degree of *tiến sỹ* [doctorate] but remained in the monastery, providing health services to the locals. At age fifty five he was sent, by royal decree, to China to serve as a court physician until his death during the Chinese Ming dynasty (1368-1643). His medical text *Hồng Nghĩa Giác Tư Y Thư* consists of two long poems: one in native Vietnamese language (chữ Nôm) Nam Dược Quốc Ngữ Phú [Native Rhyme of Southern Medicines], the second in Chinese *Trực Giải Chỉ Nam Dược Tính Phú* [A Guide to Southern Medicines], describing the pharmacological properties and clinical use of 639 medicinal herbs found in Vietnam.[56] This work also includes a section on the foundational principles of Eastern medicine, the yin-yang theory, the five elements, the physiology of the internal organs, and the pulse characteristics in diagnostics. His other works include Thập Tam Phương Gia Giảm

[55] Nguyễn Trung Hòa, *Đông Y Toàn Tập*, 33.

[56] Trần Ngọc Quý, *Y Học Cổ Truyền – Đông Y*, Trường Đại Học Y Hà Nội, Bộ Môn Y Học Cổ Truyền Dân Tộc, (Hà Nội, Nhà Xuất Bản Y Học, 2008), 10-11.

[Thirteen Medicinal Formulae], Phụ Bổ Âm Đơn [Medicine for Restoring Yin Energy] and Nam Dược Thần Hiệu [Effective Southern Medicines]. The content of this last work was later incorporated into Lãn Ông's compendium on traditional medicine. Tuệ Tĩnh's maxim "Southern medicines for Southern people" ("Nam dược trị Nam nhân") became a popular directive for later generations.

During the Later Lê dynasty (1428-1788), the code of law Hồng Đức specified the standards of practice for physicians, with penalty for incompetent physicians and immoral conducts. The law also prohibited abortion and restricted the use of tobacco. There were also state examinations to select learned and skilled physicians. The Imperial Medical Institute (Viện Thái Y) became a prestigious institute, where training and exchange between physicians took place. There were also military medical services and medical clinics established at the district level. Learned physicians were appointed to teaching positions in order to train physicians, in the Imperial Medical Institute as well as in the districts. Important medical texts were published during this era, due to greater availability of the local printing facilities. Medical tomes by earlier authors (such as Tuệ Tĩnh) were recovered and published. New medical books were compiled, of which Lãn Ông's compendium was the most complete.

3.4. *THE MORAL PRECEPTS:* TRANSLATION, NOTES, AND COMMENTARY

3.4.1. INTRODUCTION

3.4.1.1. The Text

The current text of the *Moral Precepts for Physicians* (醫訓格言) is taken from the tome 海上懶翁醫宗心領全帙 (Hải Thượng Lãn Ông Y Tông Tâm Lĩnh Toàn Trật) [The Complete Texts of Hải Thượng Lãn Ông School of Medicine], archive code A.902/1-10 of the Han-Nom Institute of Hanoi, Vietnam. The tome is wood printed in traditional Chinese, 6,000 pages, of 26 x15cm. It is part of a collection of the various imprints and manuscripts of the same work.[57] The tome A.902/1-10 is the most complete, with 56 books. The author Lê Hữu Trác, penname Hải Thượng Lãn Ông, wrote the preface to the manuscript in the year Canh Dần of the Cảnh Hưng dynastic era (1770). Imperial court scholar Lê Cúc Linh wrote the introduction. The tome begins with the foreword by the compiler Vũ Xuân Hiên, dated in the year Bính Dần of the Tự Đức dynastic era (1866). Buddhist monk Thích Thanh Cao was the chief printer, who reported that the work of carving and printing were completed in the first year of the Hàm Nghi dynastic era (1885), at Đồng Nhân Buddhist Temple, of Đại Tráng Prefecture, Võ Giàng Disctrict, Bắc Ninh Province. According to Vũ Xuân Hiên, Lãn Ông's medical texts were lost by the end of the Lê dynasty (1428-1788). Then in 1855, an old man gave to him a few books of Lãn Ông's work, which then inspired Vũ Xuân Hiên to search for the remaining books of Lãn Ông's corpus. In 1866, he was able gather over fifty books for printing, twenty one of which are from a descendant of Lãn Ông. The printing process was delayed, and was not completed until 1885. The printer Thích Thanh Cao acknowledged

[57] As listed by Lâm Giang, *Tìm Hiểu Tư Tịch Y Dược Cổ Truyền Việt Nam* (Hanoi, NXH Khoa Học Xã Hội, 2009), 365-368, there are twenty wood printed tomes and thirteen hand-written manuscripts of the same work. Each of the tomes lacks a number of books. Taken together, there are 64 different books of Lãn Ông's Corpus. The tome A.902/1-10 is the most complete.

the problem of the likely mistakes (arising from repeated hand copying) in the books that came to him. Thus, in some cases, it is not certain whether the words in the text are true to Lãn Ông's original work.[58]

3.4.1.2. Setting, Purpose, Structure, and Style

The Moral Precepts for Physicians is placed at the beginning of Lãn Ông's medical text, emphasizing its priority of place in the training and practice of the medical art. The *Moral Precepts* sets out the major themes, which are then discussed further or illustrated throughout the medical compendium, especially in the narrative pieces: prefaces to different sections of the work, and in the discussion of the cases which he treated Y Dương Án [Cases of Successful Cure] and Y Âm Án [Cases That Resulted in Death]. It is clear that the *Moral Precepts*, though inspired by earlier moral teachings within the Chinese medical tradition, reflects Lãn Ông's own values and moral norms which he wanted to pass on to his apprentices and physicians of his own school.

A close reading of Lãn Ông's medical compendium *Hải Thượng Y Tông Tâm Lĩnh* [Principles and Practice of Lãn Ông's School of Medicine] suggests that the work was intended primarily for trainees of his school. Apart from the title which reflects this intention, the contents of the compendium reveal the author's ardent desire to pass on the intricate knowledge of medical science and the secrets of the healing art that he had attained through decades of study and practice to his followers.[59] In his introduction, Lãn

[58] The possibility of falsified materials in the work has not been discussed by any scholar.

[59] This would explain his inclusion of the books such as Tâm Đắc Thần Phương [My Favorite Remedial Formulae], Y Dương Án [Cases Successfully Treated], Y Âm Án [Cases that Resulted in Death]. The disclosure of one's favorite remedial formulae is counter-intuitive, because it would give away the secret of one's craft. The report of clinical cases, especially cases that resulting in death, is exceedingly rare in

Ông related that he collected all the medical texts available, studied day and night in an isolated village, until he could understand the authors. As his knowledge and skills increased, he successfully treated many patients, he wanted to improve on the medical texts that he had read. In his own words,

> the medical learning is so vast, the medical texts so numerous, at times wordy and superfluous, making unnecessary distinctions, while the discussions of previous thinkers on illness, treatment guides and remedial formulation still have room for improvement, it is necessary to make a hundred volumes into one, to make reference easy.[60]

His motivation is also demonstrated when he cited the proverb, "Giving a remedial formula is better than giving medicine." As he explained, giving medicine can save only one person, but in giving the remedial formula, one's humane act would have lasting effects.[61] His intention was to contribute to the medical art by drawing upon the insights that he had gained from his clinical experience, to complement or correct what other authors had previously written. The *Moral Precepts* is a good illustration of Lãn Ông's methodology: to reiterate what he believed to be key elements of the tradition, to trim the superfluous or irrelevant details, to integrate into the text the insights gained from his own experience, and to present the material in his own words.

The text of the *Moral Precepts* is written in traditional Chinese script. Consistent with the classical style, the writing is concise and brisk, in some places the meaning is ambiguous. Because no punctuation is used, the reader has to decipher how the text was

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clinical practice, for it would make the physician vulnerable to critique.

[60] Lãn Ông's preface to the compendium: "Chỉ nghĩ rằng y lý quá mênh mông, số quyển rườm rà, chi tách ra lắm môn nhiều mục, tản mạn vô cùng; cùng các điều biện luận về bệnh tình, phương chỉ, phương dược của các nhà hiền triết tiền bối, còn có những chỗ chưa cặn kẽ tới nơi, cần phải đúc góp hàng trăm quyển thành một quyển, để tiện xem xét." Hải Thượng Y Tông Tâm Lĩnh, Vol. 1, 22.

[61] Ibid, 22.

intended to be read. The text is clearly divided into two sections. The first is headed with 述古 (Thuật cổ) [From Ancient Teachings], acknowledging the earlier sources behind this piece of writing. This section consists of nine precepts, each begins with 一凡(nhất phàm) [for each]. The literary style of this section is especially refined, at times with a discernible rhythmic pattern. The first of these precepts, which refers to the foundation of Eastern medical training and practice, is especially well crafted. It has a poetic rhythm, with a stanza of four syllables after the first two ideograms 一凡, then eases off with the last stanza that has seven syllables.

The second section consists of two parts, each is headed with an ideogram 懶 (Lãn), the author's cognomen, to indicate his own contribution. The first part of this section – designated IIa in this translation – contains an exhortation to medical practitioners to adhere to the high moral standards so as to be worthy of this noble profession. It also contains a warning against dishonesty, which was apparently common among physicians during the author's time. The second part of this section – designated IIb – is a piece of self-disclosure, in which the author shares his underlying motivation in the pursuit of the healing art and his own experience in applying these *Moral Precepts* to medical practice. In this very personal segment, the author also shares the obstacles he encountered and the frustration he felt through the course of his medical practice.

3.4.2. TRANSLATION[62]

[62] This is my translation of Lãn Ông's original text, which was written in traditional Chinese.

Moral Precepts For Physicians (醫訓格言, Y Huấn Cách Ngôn)

Part I: From Ancient Teachings (述古, Thuật cổ)

1. *A learner of medicine must first master the principles of Confucianism.*[63] *When one masters the principles of Confucianism, learning medicine becomes easy. During free time, one ought to study carefully the famous medical books, ancient and new, studying hard to understand and integrate the knowledge. When one has taken [the knowledge] to heart, and seen clearly with one's eyes,*[64] *one can then apply that knowledge to the hand*[65] *without making mistakes.*
2. *When asked to visit patients, one ought to give priority according to the urgency of the patient's illness. Do not give priority [in your visits] according to people's wealth or social status, nor to dispense medicine differently according to social class.*[66] *When your heart is tainted with insincerity,*[67] *it is hard to gain people's trust, or to achieve good results.*

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[63] *the principles of Confucianism Rú lĭ* 儒理 (nho lý). *Rú* 儒 (nho): lit. a *scholar*, or *scholarship*, usually indicating Confucianist scholarship; *lĭ* 理 (lý): *principle*, or *reason* behind reality. *Rú lĭ*: the principles of [Confucianist] scholarship; or the principles of the learned. For Lãn Ông, the principles of [Eastern] medicine are derived from Confucianist scholarship, thus to understand medicine requires a comprehensive knowledge of the foundational principles: the yin-yang theory, the five elements, the unity between human and nature, etc.

[64] *seen clearly with one's eyes*: likely means that, after learning what is described in the medical text books, seeing patients with such symptoms will help one's understanding. Alternatively, it can also mean seeing the texts with one's eyes helps one memorize it. Lãn Ông relates his own method of study: to collect the teachings of past thinkers, then looking at the texts and reciting aloud constantly helps him understand and remember them. Preface to *Y Hải Cầu Nguyên* [First Principles of Medicine] in *Y Tông Tâm Lĩnh*, Vol 1, 296.

[65] *apply…to the hand:* refering to the diagnostic and therapeutic acts. The diagnosis is made using four clinical skills: inspection, listening to the patient's voice, inquiring about the illness, examination of the pulse (vọng, văn, vấn, thiết). Lãn Ông, *Y Âm Án* [Cases that Resulted in Death] in *Y Tông Tâm Lĩnh*, Vol 2, 447.

[66] *dispense medicine differently*, resonates with the ancient teaching that there is only one form of medicine, for both the rich and the poor.

3. *When asked to examine women, widows or nuns[68] the physician must have an attendant [69] by his side, before entering the room for examination in order to avoid any suspicion; the same applies [when treating] female entertainers or prostitutes, the physician must strictly keep the purity of heart,[70] treating them the same as he would treat women of reputable families. Avoid every form of flirtatious behavior or it would harm your reputation, or you would bear the result of sexual misconduct.*

4. *A medical practitioner ought to think of serving others; he cannot leave his practice for recreation, taking wine to the mountain, or sight seeing; [for in such case], if a patient needs your urgent assitance, people will be anxious waiting, while a human life is in grave danger. A physician must know how important his task is.*

5. *When the patient suffers from a grave illness, and you want to do all you can to restore the patient to health, though it is a beautiful desire, you must explicitly explain [the treatment] to the patient's family before giving the prescription;[71] they will do what they can to get the medicine.[72] If the medicine brings good results, you have their admiration. Even if the illness turns worse, there will be no complaints, and you will have a clear conscience.*

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[67] *insincerity*, lack of *chéng* 誠. Sincerity (*chéng*, thành) has remained a crucial physician virtue in Eastern medical tradition since Sun Szu-miao.

[68] *women, widows or nuns* 婦女及孀婦尼姑, same three categories of persons appear in Chen's Ten Requirements (10.2), but there is difference in the wording for nuns. *Ni-cô* largely refers to Buddhist nuns.

[69] *an attendant,*侍者(*shì zhě*, thị giả): lit. a servant.

[70] *keep the purity of heart*, 存心端正, (tồn tâm đoan chính), a crucial concept in Confucianist ethics. For Mencius, to keep one's heart pure (存心) and to nourish one's nature is the way to serve Heaven (*Mencius* VIa,1). Every person of letter is required to keep the heart pure, resisting the domination of selfish and lustful desires.

[71] *you must explicitly explain… before giving the prescription* 講明方可下藥 (giảng minh phương khả hạ dược) lit. explain clearly the formula, then give medicine: to clarify to the patient's family your treatment plan before implimenting it.

[72] *they will do what they can to get the medicine* 更必盤彼藥資(*gēng bì pán bǐ yào zī zé*, canh tất bàn bỉ dược tư tắc): the meaning of this phrase is ambiguous, and can be interpreted as "*let the other take care of the medicine*" or "*take care of the medicine for the other.*" I think the former phrase is a better fit for the context. Note that there are two translation of this phrase: in the 1964 Vietnamese edition of Lãn Ông's compendium, it is translated as "lại có khi phải cho không cả thuốc" [sometimes one should give free medicine]; and in the 2008 Vietnamese edition, this is translated as "họ sẽ phải dốc tiền vào lo thuốc" [they will find money for the medicine].

6. *When buying medicinal herbs, one should select expensive items. Closely study Lei Kung's apothecary methods,[73] then prepare and preserve medicines appropriate for time and place.[74] At times one should follow exactly the existing formulae, at times modify it according to circumstances and the patient's illness. When creating a new formula, one must be directed by the sophisticated reasoning of ancient thinkers, and avoid callously creating new formulae to experiment on persons. One should have at hand adequate amounts of medicinal herbs for decoction[75] and medicine powder.[76] Medicines in tablet forms[77] and refined concentrated forms[78] must be available in adequate amounts. Being so prepared, one can provide for each patient in time, and not feel powerless when such needs arise.*

7. *When meeting colleagues, one must be humble and courteous, careful not to despise or disrespect them. To the older physician, show respect. The learned, regard as one's teacher. To the arrogant, show humility and patience. To the poorly trained, give guidance.[79] Cultivating such a virtuous character can bring many blessings.[80]*

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[73] *Lei Kung* 雷公 Lôi Công, renowned Chinese accupuncturist and apothecarist. In his medical compendium, Lãn Ông consulted Lei Kung's apothecary manuals in writing the chapter Dược Phẩm Vậng Yếu [The Essentials of Herbal Medicines], along with the works Phùng Thị Cẩm Nang [The Manual of the Phung Family] and Cảnh Nhạc Dị Sinh Nhập Môn [Introductory Manual to Canh Nhac School].

[74] *time and place* 辰處. 辰(thần): time of day. In ancient time, people divided the day into twelve parts and named them according to the twelve Earth Stems (commonly known as the Chinese Zodiac): tí, sửu, dần, mão, thìn, tị, ngọ, mùi, thân, dậu, tuất, hợi. They also calculated the day cycle according to these twelve Earth Stems. A cycle thus consisted of twelve days, which is named *thần* (辰). Thus *thần* indicates both "time of the day" and "day of the twelve-day cycle." 處 (xứ): place. Eastern apothecarists believe that the nature or quality of the medicine is affected by environmental factors, such as heat, degree of humidity, season, and time of day.

[75] *medicinal herbs for decoction* 湯 (thang): medicinal herbs often dispensed in combination according to a certain apocathery formula (phương thuốc), used for decoction.

[76] *medicine powder* 散 (tán): medicinal bark, root or plant ground into a powder.

[77] *medicines in tablet forms* 丸(hòan): herbal tablet, usually made out of herbal powder mixed with honey or rice liquid.

[78] *refined concentrated forms* 丹(*đan*): a form of herbal medicine that comes as a single pill.

[79] *To the learned… to the poorly trained:* reveals the discrepancy in the level of training and competency of the practitioners of his time.

8. *When visiting patients from very poor families, the orphans, the widows, the childless elderly,*[81] *the more one must make special efforts to provide care. For persons of wealth and status, you need not worry about their lack of medical care; but poor and lowly persons are unable to invite famed physicians. If one devote whole-heartedly to the person for a short time,*[82] *his (or her) life will be saved. When very dutiful children, or very dedicated wives become sick because of extreme poverty, besides giving free medicines, one should also provide for them according to one's means, for persons who have medicines but no food to eat also perish.*[83] *One must care for the person's life in its totality to be worthy of the art of humaneness.*[84] *Those who become poor and sick from reckless exploits*[85] *do not deserve as much sympathy.*[86]

9. *After the patient is cured, one must not ask for lavish gifts in return, because recipients of [lavish] gifts often become subservient.*[87] *Not to mention the fact that persons of wealth and status are often unpredictable in their attitude; those who seek glory [from them] often bear shame; those who try to please [them] for personal gain*

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[80] *cultivate a virtuous character*: this phrase puts together two separate concepts 存心 (tồn tâm): lit. to guard one's heart from selfish and lustful desires, a major element of Confucianist ethics (cf. Precept 3). 德厚 đức hậu: full of virtue.

[81] *the childless elderly* 獨 (độc): an elderly person who lives alone without children's support.

[82] *one devote whole-heartedly… for a short time* 一刻之誠心 (nhất khắc chi thành tâm): lit. sincere heart for a short period. Again, refering to sincerity of heart, which is a core medical virtue (cf. Precept 1).

[83] *persons who have medicines but no food to eat also perish* 有藥而無飲食同歸於死, (hữu dược nhi vô ẩm thực đồng quy ư tử) cf. Chen Shih-kung's text: 有藥無食 (hữu dược vô thực)

[84] the art of humaneness 仁術 (nhân thuật): or Unschuld's translation "practiced humaneness" is how Lãn Ông defines medical practice. This phrase appears twice again in this text.

[85] *reckless exploits* 遊手流蕩(du thủ lưu đãng)**:** lit. persons who go from one place to another to engage in pleasure-seeking behavior (which may involve alcohol and sex). In addition, such drifting individuals would often escape social duties, such as military and community services, or paying taxes. According to the law code under the reign of Lê Thánh Tông (1460-1497), drifting individuals were not allowed to be registered in the civil registry, while immigrants were allowed registration. Phạm Văn Sơn, *Việt Sử Toàn Thư,* 278.

[86] The cause of this "special care for the virtuous" is rooted in the understanding of the virtue of humaneness (仁, nhân) in Confucianist ethics, which is discussed in detail in the section that follows.

[87] *become subservient* 受人賜者當畏人(thụ nhân tứ giả đương úy nhân): lit. recipients are often fearful [of the benefactors], thus unable to maintain a respectable distance.

would reap unpleasant results. The healing art is a dignified art, the practitioner must cultivate a dignified character.[88]

Part IIa:懶 Lãn Ông's Narrative

I consider the moral teachings of the great sages of old on kindness and the cultivation of virtues very solid and sufficient. Medicine is an art of humaneness,[89] *specialized in the service of human lives. [The physician] bears the worries of others, rejoices in the joy of others,*[90] *only considers saving human lives as one's duty; does not induce gifts by recounting the labor. [By acting in this way] though one may not receive immediate return, one leaves a good legacy for posterity.*[91] *If a proverb says, "Three generations of practicing medicine will enable someone among one's descendants to ascend to high public office,"*[92] *is it not the fruit of much cultivation [by the forebears]? One often finds physicians in the present day taking advantage of either persons whose parents suffer from severe illness, or persons who come on a rainy night for urgent needs: seeing an easy case they say it is difficult to treat; seeing a difficult case, they say it is incurable, using such wicked means to obtain what one desires is unconscionable. When treating persons of great status, [those physicians] show tremendous care in order to gain benefits in return;*[93] *when treating persons who live under thatched roof, they are cold*

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[88] *dignified art… dignified character* 清高之術…清高之節 (thanh cao chi thuật… thanh cao chi tiết). 清 (thanh): purity; 高(cao): elevated. *Thanh cao* means honorabbe and freed from political or worldly affairs. Because of the pure and elevated nature of the medical profession, the pratitioner ought to cultivate a moral character appropriate for the practice.

[89] *medicine is an art of humaneness* 醫之為道仁術 (y chi vi đạo nhân thuật), lit. the *dao* of medicine is the art of humaneness.

[90] *bears the worries of others, rejoices in the joy of others*: 憂人之憂樂人之樂 (ưu nhân chi ưu lạc nhân chi lạc) lit. make others' worries one's own worries, make others' joy one's own joy. This has become a celebrated phrase in Vietnamese traditional medicine.

[91] *a good legacy for posterity* 陰隲 (âm chất, synonym 陰德 âm đức): a good non-material heritage, resulting from one's generous acts, that one passes on to future generations who may reap great benefits, including material benefits such as wealth and social status.

[92] *high public office* 卿相 (khanh tướng): lit. minister and general, i.e. to reach the top ranks in political or military career.

[93] *to gain benefits* 利欲 (lợi dục): lit. to satisfy one's selfish desires. According to Confucianist teachings, to let selfish desires dominate one's thinking indicates the person's moral decadence.

and careless, the cause for people's bitter complaints. Alas! The art of humaneness, the art of service to human lives, the humane heart[94] is turned into the heart of the market place.[95] [That such behaviors] are scolded by the living and condemned by the dead[96] is beyond discussion.

Part IIb: 懶 Lãn Ông's Narrative

I have freed myself from ambitions for high office,[97] and content with a quiet life among nature. The ancients said, "If you cannot become a good army general, then be a good physician."[98] That is why I have pledged in my heart to do all that must be done to perfect and broaden my services to others,[99] so as not to be ashamed with heaven and

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[94] *The humane heart* 仁心 (nhân tâm): the humane heart is necessary for the art of humaneness (仁術, nhân thuật).

[95] *the heart of the market place* 市井之心(thị tỉnh chi tâm): derogatory reference to trade and commerce, where self-interest is the ruling principle. According to the Confucianist tradition, the virtuous scholar ought to pursue humaneness (仁, nhân) and righteousness (義, nghĩa), rather than benefit (利, lợi) (*Mencius* Book I, Part I, Ch.1).

[96] *condemned by the dead*: the phrase indicates that such unconscionable behaviors will be judged and dealt with after death.

[97] *ambitions for high office* 志功名(chí công danh): Confucianist scholars generally aspired to serve in public office through passing state examinations, so as to make use of their learning in the governance of the state. This aspiration was often the motivating factor among students and scholars of the Confucianist tradition, which is captured in *The Great Learning*: 格物,致知,誠意,正心,修身,齊家,治國,平天下(cách vật, trí tri, thành ý, chính tâm, tu thân, tề gia, trị quốc, bình thiên hạ): to investigate the nature of things, to extend one's learning, to make one's will sincere, to correct one's mind, to cultivate one's person, to regulate one's family, to order one's state, to set the world at peace. In this paragraph, Lãn Ông clarifies that his motivation for learning is not to attain public office, for he is content to be a good physician. In another section of personal narrative (preface to *Cases that Resulted in Death*), Lãn Ông considered himself an unsuccessful scholar who had not passed the state examinations, thus unable to continue the family tradition in the achievement of academic degrees and public office.

[98] *cannot become a good army general*: allusion to his brief military career. Again, his sense of failure to achieve the higher stations in life. Lãn Ông's writings reveal that the practicing physicians of his time were not as highly regarded as state officials or commanding army officers.

[99] *to perfect and broaden my services* 深其博濟 (thâm kỳ bác tế): lit. deep and broad charitable services.

earth.[100] *When facing untreatable cases, I felt powerless, and yielded to the dictate of fate;*[101] *yet there were also treatable cases but my hands were tied, I could only watch while the illness ran its course. For without the means, one cannot devote whole-heartedly*[102] *to the task [of saving the patient], thus there is nothing else to do but sigh. Tần Việt Nhân*[103] *once said, "To prefer wealth to health is the second untreatable disease; not being able to afford food and clothing is the third untreatable disease."*[104] *In*

From his writings, it is clear that Lãn Ông did not provide services *gratis* in every case, but receiving remuneration was the standard practice. In the sentences that follow, Lãn Ông again mentions the problem of poverty (as he did in Precept 8), and reveals that at times he did provide free services (perhaps also food and clothing) to persons in dire need, practicing what he teaches in Precept 8. By providing free services to poor families, he "broadens" his services, making them available also to those who could not afford to pay. Note that the two ideograms 博 (*bó*, bác) and 濟(*jì*, tế) are part of a key text in the *Analects* 6.30 on humaneness (*rén*). See explanation on page 50. The ideogram 深 (thâm) could be interpreted as either to *perfect his medical art* (professional competence), or to *make his charitable services more thorough* for the beneficiaries.

[100] *ashamed with heaven and earth* 庶無俯仰之愧 (thứ vô phủ ngưỡng chi quý): lit. to "avoid shame when looking down and looking up," i.e. at earth and heaven. The phrase means to have a clear conscience, free from shame and regret.

[101] *dictate of fate* (天命): by "fate" I follow Tao Lee's translation of (命) in Chen Shih Kung's text. See Tao Lee, "Medical Ethics in Ancient China" in Veatch, *Cross Cultural Perspectives in Medical Ethics: Readings*, 135-136.

[102] *without the means, one cannot devote whole-heartedly* 力不得盡心不能 (lực bất đắc tận tâm bất năng): lit. without the power, one cannot give the whole heart [to the task]. Note the author's frustration in facing a such case: though willing to do all he can for the patient, he is not able to do so, because of the lack of adequate resources.

[103] Tần Việt Nhân 奈越人 is the author of *Bashiyi Nanjing* 八十一難經 [The Classic of Eighty-One Difficult Issues] (often referred to as *Nan Jing*), which is among the Classics of traditional Chinese medicine. This author together with his work is mentioned in Lãn Ông's Preface to his medical compendium.

[104] *untreatable disease*: with this quotation, Lãn Ông begins explaining two major causes of lack of resources: (i) people's stinginess; and (ii) poverty. For the author, the unwillingness to spend money to save lives, and the lack of food and clothing due to poverty are also considered "illnesses." In the first case, it seems that Lãn Ông refers primarily to persons who are too tightfisted to spend money on medical treatment for themselves or a member of their family, rather than criticking wealthy people who are

such cases, though they considered [human life] lightly, I considered it a weighty matter; though they lacked [food and clothing], I was willing to provide, then no need for worry.[105] *Alas! Generous means and a generous heart,*[106] *it seems impossible to have both. Without adequate means, medical practice seems to be less than half what it could be.*

3.4.3. COMMENTARY ON LÃN ÔNG'S MORAL PRECEPTS

The text is full of terms and phrases derived from the *Chinese Classics*, especially the *Four Books* of Confucianism, suggesting that the author is well grounded in the Confucianist tradition. His careful distinction between the teachings of earlier thinkers and his own contribution shows a scholarly respect for the tradition, and a desire to make it accessible to others. The nine precepts clearly show the influence of earlier authors of the Chinese medical tradition, especially of Chen Shih-kung's *Five Commandments* and *Ten Requirements*. As I have discussed, Chen Shih-kung's medical ethic bears the marks of the long moral tradition from Sun Szu-miao onward, especially of the works of the

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indifferent to the suffering of poor persons outside their family circle.

[105] *no need for worry*: the physician's willingness to make up for what is lacking in the patient, namely, stringiness or poverty. This means providing free services and medicines to the patients, as well as food and clothing for those in dire need.

[106] *Generous means ... generous heart* 恆產, 恆心 (hằng sản, hằng tâm): the expressions come from the book of *Mencius*. In the original context, Mencius explained that without the possession of generous means, only the scholars can maintain a generous heart, for without generous means the average citizens cannot maintain a generous heart. Thus, Mencius insisted that the good ruler should help citizens attain material wealth, so that they may have both the means and the disposition to support the affairs of the state (*Mencius*, Book I, Part I, ch 7). In light of this, Lãn Ông implies that a scholar with a generous heart as he is, he can do little without generous means.

Confucianist physicians: Chang Kao, Chu Hui-ming, Kung Hsin and Kung T'ing-hsien. Lãn Ông's medical ethic belongs to this same tradition, and similar to Chen Shih-kung's ethic, bears the distinctive influence of the Confucian physicians. In the *Moral Precepts,* Lãn Ông's reference to medicine as practiced humaneness (仁術, *ren-shu,* nhân thuật) has its origin in the writings of the Confucian physician Lu Chih. Lãn Ông's views on physician competence, equal treatment for the rich and the poor, empathy with patients, and the retribution for physician conduct are characteristic of the moral tradition that began with Sun Szu-miao. Lãn Ông's assertion that physicians ought to master "the principles of the scholar" resonates with Chen Shih-kung's *Ten Requirements*, which in turn reflects the *Ten Maxims for Physicians* by an earlier author Kung T'ing-hsien. Lãn Ông's assertion is a clear indication that he considered himself a Confucian physician (*rú-yi*: 儒醫, nho y). Lãn Ông's own background as a Confucian scholar also places him among the scholar-physicians Lu Chih, Chu Hui-ming, Kung Hsin and Kung T'ing-hsien who turned to medicine after an academic career. In the same tradition of these physician authors, Lãn Ông compiled his own medical compendium in order to *preserve*, *refine* and *enrich* the tradition, which is characteristic of Confucian scholarship. Also in line with the Confucian scholarly tradition is the exhortation to study hard from textbooks in order to excell in one's art and to cultivate one's character.

My parallel study of Lãn Ông's *Moral Precepts* and Chen Shih-kung's *Five Commandments/ Ten Maxims* reveals the way Lãn Ông redacted Chen's text: preserving what he considered important, trimming what seemed irrelevant or superfluous, refining

the earlier concepts, and bringing his own ideas into the discourse.[107] I now examine the way Lãn Ông edited the earlier text and what he added to it, in order to demonstrate his distinctive contribution to the moral discourse. Note that Lãn Ông's *Moral Precepts* were written primarily for his disciples, that is, physicians and apprentices of Lãn Ông's school.

In his first precept, Lãn Ông's insistence that the physician ought to master the principles of Confucian scholarship provides his followers with the stepping stone into the study of medicine. Because his intended reader is the apprentice of this school, he is concerned with producing competent physicians, who possess a depth of learning, and a strong basis for medical reasoning, so as to apply the knowledge to the diagnosis and treatment of patients. For Lãn Ông, medical practice must have a sound foundation, and physicians must have sufficient knowledge of the principles and reasoning methods of medicine. From these foundational principles and reasoning methods, the physician can deduce the treatment for each case, or even create new apothecary formulae to suit the individual patient (Precept 6). In giving priority of place to this precept, Lãn Ông emphasized that professional competence must be the primary concern for the practitioner of the medical art.

From a different perspective, this precept can also be viewed as an attempt to make Confucianist medicine the norm, and indirectly discredit other healing practices that were not based on Confucianist thought: the practices of the "unorthodox" herbalists, the masters of the amulets, the magicians, and the sacrificers. Thus, Lãn Ông's

[107] See Appendix II "Chen Shih-kung's Five Commandments/Ten Maxims and Lãn Ông's *Moral Precepts* in Parallel."

promotion of Confucian learning can be interpreted as the promotion of the professional standards of a particular group of practitioners, namely the Confucian physicians, to which he belonged. From this vantage point, Lãn Ông's directive to show respect and courtesy to "colleagues" 同道之士 (đồng đạo chi sĩ) in Precept 7 would refer to behavior toward physicians of the same school,[108] rather than healers in general. This represents the awareness of the practicing physicians who saw themselves as a professional group, sharing some common interests. Within the group of Confucian physicians, the members were bound together by the same system of thought and a common set of values which defined the group identity. Precept 7 also seems to reflect the different levels of training that physicians of this group received. In light of this, to study hard to improve one's art (Precept 1), to cultivate one's character as a physician, to support and to show courtesy toward one's colleagues (Precept 7) all contribute toward the advancement of the social standing of one's professional group.

Lãn Ông's second precept insists on equal treatment of the rich and the poor, which is consistent with the Chinese medical tradition since Sun Szu-miao. In addition, this also reflects Lãn Ông's special concern for the poor which he elaborates further in Precept 8. Physicians ought to extend equal regard also to female entertainers and prostitutes, who were the most despised members of society (Precept 3). His promotion of the virtue of sincerity (*chéng* 誠, thành), which had been an important part of the Chinese medical tradition since Sun Szu-miao, also contributes toward the formation of trustworthy

[108]This respect is related to the Confucianist conviction that one can learn from one's companions as well as from one's teachers. In the *Analects*, Confucius said that "Even when walking in the company of two other men, I am bound to be able to learn from them. The good points of the one I copy; the bad points of the other I correct in myself." 子曰：「三人行，必有我師焉。擇其善者而從之，其不善者而改之。」(*The Analects* 7.22).

physicians.

Precept 3 follows Chen Shih-kung's advice on the presence of the chaparone in the examination of women patients (Chen's 5.2), and reiterates Chen's directive about equal treatment for prostitutes (Chen's 5.5). Lãn Ông added an emphasis on the "purity of heart," reminding the reader that medical practice is a way of self-cultivation. In his Preface to a book in his medical compendium "Y Hải Cầu Nguyên" [The Foundations of Medicine], Lãn Ông insisted that medicine as a dignified human art, offers a *pathway* (醫道, y đạo) for the moral and spiritual cultivation of the practitioner. In line with Mencius' teachings (*Mencius* 4A.1), Lãn Ông insisted that to keep the purity of heart 存心端正 (tồn tâm đoan chính) is a basic moral task of the practitioner, because the pursuit of the virtues involves resisting the domination of selfish and lustful desires. In precept 9, Lãn Ông defined medicine as a dignified art 清高之術(thanh cao chi thuật) that should not be tainted by the desires for personal gain or political ambitions.

In Precept 4, Lãn Ông expanded on Chen's assertion about the physician's availability, and pointed to the *social responsibility* of the physician. It is not clear if Lãn Ông suggested that physicians had to be available for service at all times. It is likely that he simply cautioned physicians against taking extended periods away from their practice for recreation purposes. According to Lãn Ông, as physicians are guardians of human life, they ought to be aware of the social responsibility given them by society.[109]

Precept 5 is Lãn Ông's innovative contribution on the importance of adequate

[109] For instance, in the Moral Precepts for Physicians, Narrative Part A: "Medicine is an art of humaneness, specialized in the service of human lives. [The physician] bears the worries of others, rejoices in the joy of others only considers saving human lives as one's duty."

explanation of the treatment to the patient and/or their family. In modern terms, this is the requirement of adequate disclosure of information, which would allow patient participation to occur. Lãn Ông had in mind the kind of explanation that would lead to patient agreement and cooperation, such that no complaints will follow, even if the outcome is undesirable. This disclosure of information aims toward reaching an agreement with the patient and/or the family regarding the treatment plan prior to giving treatment.

In Precept 6, Lãn Ông's insistence on buying good quality ingredients aims to increase reliability and encourage trust in physicians. Comparing to Chen Shih-kung's text, Lãn Ông's precept gives much more leeway to the physician in regard to the creation of new medicinal formulae, though not without caution. Lãn Ông does not advocate rigid adherence to the existing formulae, but allows the well trained physicians to modify or create with care, based on the reasoning methods that they have acquired through their training. Physicians ought to avoid callously creating new formulae then test them on people.

Precept 8 is Lãn Ông's most significant contribution to the medical ethical discourse, for it highlights and further specifies the *social responsibility* of physicians. According to Lãn Ông, care for the orphans, the widows, the childless elderly is part of the physician's responsibility. As guardians of human lives, the physicians ought to reach out to those who cannot afford medical care, to such an extent as to provide them with free medicines *as well as* food out of one's own resources. In his Narrative section IIb, Lãn Ông related his own experience in living out this moral ideal. He expressed frustration with people's stinginess, and at times felt powerless in the face of the poverty of patients.

In Precept 9, Lãn Ông edited Chen's text to make it applicable to a broader context of clinical practice. Of note is Lãn Ông's definition of medicine as a dignified profession which requires a dignified character. Again, his emphasis on the moral character of the physician is unambiguous. To pursue the medical art fully, one ought to be free from greed, and take care to cultivate one's moral character.

Lãn Ông omitted Chen's analogy between the person's health and the family's livelihood (10.4); reference to the person's fate and conscience (10.5); advice on simplicity of lifestyle (10.6); and directive on investment in real estate (10.8). Lãn Ông also left out Chen's significant directive on confidentiality in regard to the patient's information (5.2). However, Lãn Ông's narrative section seems to reflect Chen's reference to reward and retribution for physician conduct (10.5).

In the first narrative section (IIa), Lãn Ông reiterated the essentials of medical ethics. As practitioners of the art of humaneness (仁術, nhân thuật) and as guardians of human lives, practitioners ought to be concerned primarily with saving lives, rather than seeking profit. A good physician is committed to the service of others and shows empathy by sharing the worries and the joys of others. To substantiate his moral claims, Lãn Ông argued on the basis of two moral theories that were widely accepted in his cultural context: (1) shame/ honor which is related to the Confucian theory of Rectification of Names (正名, chính danh); and (2) the concept of leaving a good legacy for posterity (陰德, *Âm đức*), which is related to the Daoist doctrine of retribution (*chéng-fù* 承負, "transmission of burden").[110] As we have seen, the ideas of reward and

[110] Kenneth K. S. Ch'en, *Buddhism in China: A Historical Survey,* (Princeton NJ: Princeton University

retribution for physician conduct have been part of the Chinese medical tradition from Sun Szu-miao onward.[111] Reward and retribution also featured significantly in Chang Kao's anecdotes and Chen Shih-kung's *Ten Requirements for Physicians* (10.5).

According to the theory of the Rectification of Name, things should actually be made "to accord with the implication attached to their names."[112] Confucius believes that the right order of society is dependent upon each person performing his or her prescribed social role: the ruler fulfilling his role as a ruler; parents fulfilling parental duties; children fulfilling their filial obligations (*The Analects* 12.11). In the *Analects*, Confucius explains that rectification of names is indispensable because,

> If names be not correct, language is not in accordance with the truth of things. If language be not in accordance with the truth of things, affairs cannot be carried on to success. When affairs cannot be carried on to success, proprieties and music will not flourish. When proprieties and music do not flourish, punishments will not be properly awarded. When punishments are not properly awarded, the people do not know how to move hand or foot. Therefore a superior man (君子) considers it necessary that the names he uses may be spoken appropriately, and also that what he speaks may be carried out appropriately. (*The Analects* 13.3).[113]

Every name therefore implies certain responsibilities and duties within the web of social relationships. The names *ruler, minister, father*, and *son* indicate specific roles within the society that is defined in terms of social relationships. As Fung Yu-lan explains, there ought to be "agreement between name and actuality," otherwise the thing

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Press, 1964), 48-52.

[111] Note Sun Szu-miao's attribution to Lao-Tzu the saying, "Open acts of kindness will be rewarded by man while secret acts of evil will be punished by God" in footnote 39.

[112] Fung Yu-lan, *A Short History of Chinese Philosophy,* 41. See also Chung-ying Cheng, "Zhengming (Cheng-ming): Rectifying Names" in Cua, *Encyclopedia of Chinese Philosophy*, 870-872.

[113] Translation by James Legge, available at http://ctext.org/analects/zi-lu. Accessed October 15, 2012.

bearing such a name will not be recognized as such.[114] For instance, if a ruler acts according to "the way of the ruler," he is then truly a ruler, "in fact as well as in name." If he acts contrary to it, he is no ruler, even though he may bear that title. For this reason, the individuals bearing these names must fulfill their responsibilities and duties accordingly, for the viability of society is dependent on it. It is apparent that Lãn Ông had this in mind when he insisted that the physicians, who aspire to practice the art of humaneness, ought to conduct themselves in manners worthy of that name. In defining medicine as the art of humaneness, Lãn Ông identifies the *essential* nature of medicine, and the *role* of the medical practitioner, with the social responsibilities and duties that it entails. The physician who fulfils these responsibilities and duties according to the dictate of humaneness is truly a physician. Ones who act contrary to it are not worthy of that name.

In the second narrative section (IIb), Lãn Ông clarifies his underlying intention and desires in embracing medicine. In declaring his lack of political ambition, he affirms his commitment to medicine, and to the service of others through medical practice. In other words, medical service is for him an end in itself, rather than a stepping stone into a political career. It seems that Lãn Ông expected a similar commitment from his followers who aspired to practice the healing art. Lãn Ông then goes on to relate his own experiences in medical practice, in view of the very high moral standards that he outlines. Committed to these high ideals as he was, there were often obstacles to good medical practice, and the physician is called to a high level of dedication to human lives.

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[114] Ibid, 41-42.

Sometimes this entails providing for people's needs out of one's own resources. Lãn Ông's *Moral Precepts* then ends with a sigh. Even highly committed to the moral ideals, at times the physician would feel powerless because of the social and human factors beyond his or her control.

3.5. LÃN ÔNG'S MEDICAL ETHICS

3.5.1. Background: Confucianist Ethics as a Virtue Ethics

In the first chapter, I argue that the Aristotelian teleological structure provides the most adequate foundation for physician virtues. Aristotle's virtue theory is based on a concept of human nature that is oriented toward a *telos*, which he calls the human good. [115] Virtues are character traits and personal excellences that enable the person to achieve this end. There is an interlocking web of intrinsic goods that we need for living a good life, and among such intrinsic goods is health. [116] Medicine is committed to the health of patients, and this commitment determines both the physician's role and the medical virtues that enable physicians to meet the goal of serving patient health.[117] In addition, the activity in accordance with the medical virtues (such as benevolence or justice) under the guidance of prudence is partly constitutive of the human good of the physician who practices them.

From the Confucianist perspective, the moral life is also centered on the

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[115] Aristotle, *Nicomachean Ethics*, 1101a 14-16.

[116] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001), 15.

[117] Ibid, 92-93.

cultivation of virtues. The opening line of *The Great Learning* provides the basic principles for the scholar, "The *Dao* of great learning lies in manifesting illustrious virtue, in making the people new, in abiding in the highest good."[118] Often *de* (德) is translated as virtue because it connotes the personal qualities of an exemplary person. As Wing-Tsit Chan rightly observes, Confucius himself believed in "the perfectibility of all men," such that he transformed the traditional concept of the *jūn zǐ* (君子) into a moral ideal attainable by all.[119] *Jūn zǐ* which literally means "son of the ruler," and originally carried with it the concept of nobility derived from hereditary, was used largely by Confucius to refer to the exemplary person, or the model of virtue. Because of Confucius' contribution to Chinese thought, "nobility was no longer a matter of blood, but of character."[120] Confucius, who persistently avoided reference to spiritual beings or life after death, had as his primary concern a good society based on good government and harmonious human relations.[121] In his view, the good ruler is one who rules by virtue and moral example rather than by coercion. Confucius looked to sage emperors Yao and Shun and Duke Chou as ideal models for imitation. In this context, *de* is the key to good governance, for it denotes the ruler's moral authority to command respect and obedience from others without the use of military force or violence.[122] In the *Analects*, Confucius

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[118]大學之道、在明明德、在親民、在止於至善。

[119] *Jūn zǐ* (君子) appears 107 times in the *Analects.* Occasionally it refers to the ruler, but in most cases, Confucius used it to indicate the exemplary man. It has been translated as "the gentleman," "the superior man," "the paradigmatic person." I use the last option for its inclusiveness. Wing-Tsit Chan, *A Source book in Chinese Philosophy*, (Princeton/ New Jersey: Princeton University Press, 1963), 15. Also James T. Bretzke, "The Tao of Confucian Virtue Ethics" in *International Philosophical Quarterly* Vol. 35, No. 1 Issue No. 137 (1995), 27-29.

[120] Ibid.

[121] Ibid, 15.

[122] See also Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy* (New

said, "To rule by virtue is like the Pole Star: it remains in its place and the crowd of stars bow around it" (*Analects* 2.1). To possess *de* (virtue) is therefore to possess the power to affect one's self, other people, and the world.[123]

In 1977, the renowned Chinese Canadian scholar Julia Ching published an insightful work on the correlation between Confucianism and Christianity.[124] Following her lead, other scholars have produced further comparative studies of Confucianism and Western thought.[125] While each tradition is distinctive, there are similarities identifiable across the cultural boundaries. For instance, moral philosopher May Sim points out that "habituation into virtue, social relations, and paradigmatic persons are central for both Aristotle and Confucius."[126] Each tradition would agree to the concept of virtue as "a disposition to act, desire, and feel that involves the exercise of judgment and leads to a

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York: Cambridge University Press, 2007), 65-68; Lee Yearly, *Mencius and Aquinas,* 54.

[123] Lee Yearly, *Mencius and Aquinas,* 54. Because of the different meanings behind the word, de 德 has also been translated as "power" of described in terms of the good will or "psychic force" generated by generosity, kindness, forbearance, humility, respect and self-sacrifice. See David S. Nivison, "De (Te): Virtue or Power" in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy* (New York/London: Routledge, 2003), 234-235.

[124] Julia Ching, *Confucianism and Christianity: A Comparative Study* (New York: Kodansha International, 1977). The earliest works of comparison between the two traditions were in fact done by Jesuit missionaries to China. For a discussion on the contributions of Jesuit scholars (especially of Matteo Ricci), see John D. Young, *Confucianism and Christianity: The First Encounter* (Hong Kong: Hong Kong University Press, 1983); also Lionel M. Jensen*, Manufacturing Confucianism: Chinese Traditions and Universal Civilization* (Durham and London: Duke University Press, 1997); Jean - Paul Wiest, "Matteo Ricci: Pioneer of Chinese-Western Dialogue and Cultural Exchanges" in *International Bulletin of Missionary Research*, Jan, 2012, Vol.36(1), 17-21.

[125] See, for example, Lee Yearly, *Mencius and Aquinas* (Albany: State University of New York Press, 1990); Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy* (New York: Cambridge University Press, 2007); May Sim, *Remastering Morals with Aristotle and Confucius* (New York: Cambridge University Press, 2007); Jiyuan Yu, *The Ethics of Confucius and Aristotle: Mirrors of Virtue* (New York: Routledge, 2007).

[126] May Sim, *Remastering Morals with Aristotle and Confucius,* 134-135.

recognizable human excellence or instance of human flourishing."[127] Bryan van Norden more explicitly defends the view that Confucianist ethics (which he calls *Ruist* ethics) is a virtue ethics. He explains,

> [Confucius] emphasizes becoming the sort of person who can discern and respond to complex and fluid situations. This leads naturally to an interest in the way of life of such a person, the virtues that contribute to leading such a life, the cultivation of those virtues, and (implicitly) how human nature allows us to cultivate those virtues and lead that life.[128]

However, van Norden also stresses that Confucianists do not share the two-world metaphysical views held by Plato and Aquinas, because their ethics focuses on living well in this world within concrete human relationships.[129] From the Confucianist perspective, the good life consists in "participation in ritual activities, ethically informed aesthetic appreciation and intellectual activity, acting for the good of others, and generally participating in relationships with other people, especially familial relationships."[130]

In this context, a number of virtues have been emphasized through the history of Confucianism, which include: *rén* 仁 ("humaneness"), *yi* 義("righteousness"), *lǐ* 禮 ("propriety"), *zhì* 智 ("wisdom"), and *xìn* 信 ("faithfulness").[131] Even in this brief overview, two key virtues *rén* 仁 and *yi* 義 warrant some exposition. *Rén* 仁 is

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[127] Lee Yearly, *Mencius and Aquinas,* 13, also 53-58. James T. Bretzke, "The Tao of Confucian Virtue Ethics" in *International Philosophical Quarterly* Vol. 35, No. I Issue No. 137 (1995), 25-27.

[128] Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy* (New York: Cambridge University Press, 2007), 99.

[129] Ibid, 100.

[130] Ibid, 101.

[131] Cf. ibid, 117.

undoubtedly the most important virtue in the *Analects*. Moreover, *rén* is also understood as the combination of a number of virtues, or even the summation of all the virtues.[132] As Tu Wei-ming puts it, *rén* is "the virtue of the highest order in the value system of Confucianism" because it "gives 'meaning' to all the other ethical norms that perform integrative functions in a Confucian society."[133] As Tu also explains, *rén* is linked with the internal process of the cultivation and moral perfection of the self. Confucius summarily taught that *rén* is "loving others" (the *Analects* 12.22). In the *Analects* 6.30, when the disciple Tzu-kung asks the Master whether "a man who gave extensively to the common people and brought help to the multitude" could be called *rén*, the Master answered that such a person is beyond *rén*: he ought to be called "sage," for the sage kings Yao and Shun would have found it difficult to accomplish as much.[134] Confucius went on to say,

> The man of ren is one who, wishing to get himself established (eg. in public office), also helps others to get established; wishing to succeed, also helps others to succeed. To be able from one's own self to draw a parallel for the treatment of others, that may be called the way to practice *ren* (the *Analects* 6.30).

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[132] Wing-tsit Chan points out that though Confucius at times uses ren to indicate a particular virtue, Confucius most often refers to ren as the summation of virtue. Wing-tsit Chan, *A Source Book in Chinese Philosophy,* 16.

Cf. Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy*, 117-118; also Fung Yu-lan, *A Short History of Chinese Philosophy,* 42-43.

[133] Tu Wei-ming, *Humanity and Self-Cultivation: Essays in Confucian Thought* (Berkeley: Asian Humanities Press, 1979), 6-9.

[134] Original: 子貢曰："如有博施於民而能濟眾，何如？可謂仁乎？"子曰："何事於仁，必也聖乎！堯舜其猶病諸！夫仁者，己欲立而立人；己欲 達而達人。能近取譬，可謂 仁之方也已。" This quotation, "to give extensively to the common people" *bó shī yú mín* **博施於民** (bác thí ư dân) and "to bring help to the multitude" *néng jì zhòng* **能濟眾** (năng tế chúng) contain two key words *bó* **博** and *jì* **濟** that link with Lãn Ông's narrative in the *Moral Precepts for Physicians*. In light of this text, Lãn Ông's narrative discloses his aspiration to give and to bring help to the common people. See footnote 97 on page 37.

Rén is also explained in terms of *zhong* 忠 ("loyalty") and *shu* 恕 ("reciprocity"), the two words that capture the *dao* of the Master (the *Analects* 4.15).[135] This is often known as the principle of *zhong shu* 忠恕, by which one can discern what one ought to do (or not do) to another person, asking what one would like or dislike were one in the other's position.[136] However, Confucius does not demand an equal love for all persons (as Mo Tzu does), but advocates a "graded love" that favors more those bound to the agent by special relationships.[137] The Confucianist tradition identifies Five Relationships: ruler-minister, parent-child, husband-wife, elder sibling-younger sibling, and friend-friend (*Doctrine of the Mean* 20; *Mencius* 3A.4).[138] For Confucius, the son is not required to report the father who has stolen a sheep to the authority, for "uprightness" is found in honoring the special bonds of relationship (*Analects* 13.18). Furthermore, Confucius maintains that "Only the person of *rén* knows how to like, and to dislike others

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[135] E. Bruce Brooks argues that 4.15 is not part of the original *Analects*, but a later insertion by followers of Zeng Shen. See, *The Original Analects: Saying of Confucius and His Successors*, (New York: Columbia University Press, 1999), 249-479. In spite of this dispute, it is clear that *zhong* and *shu* are central to Confucius' teachings.

[136] See D. C. Lau, *The Analects,* 2nd ed, (Hong Kong: The Chinese University Press, 1992/2000), xv-xvi. For a discussion on the different interpreations of *zhong* and *shu,* see David S. Nivison, "Zhong (Chung) and Shu: Loyalty and Reciprocity" in Cua, *Encyclopedia of Chinese Philosophy*, 882-885. Fung Yu-lan explains that zhong 忠 and shu 恕 are identical to the two forms of the Golden Rule in the Western tradition: zhong 忠 is understood as "doing onto others what one would desire for oneself," while shu 恕 means, "Do not do to others what you do not wish for yourself" (the *Analects*, 12.2). The practice as a whole is called the principle of *zhong shu* 忠 恕. See Fung Yu-lan, *A Short History of Chinese Philosophy,* 42-43.

Bryan Van Norden argues that *zhong* is also a virtue term, while *shu* is not. See *Virtue Ethics and Consequentialism in Early Chinese Philosophy*, 119. Fung tends to interpret Confucianist ethics more in terms that mirror Kantian deontology. For instance, in his the discussion on yi 義, Fung refers to "the oughtness of a situation," "duties," and "categorical imperative." While this interpretation is certainly legitimate, it does not do justice to the fact that *yen* is also a virtue term. See Fung Yu-lan, *A Short History of Chinese Philosophy,* 42-43.

[137] See Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy*, 114-115.

[138] Of these, three are recognized as the most important, known as the Three Bonds: ruler-minister, father-son, husband-wife. See James T. Bretzke, "The Tao of Confucian Virtue Ethics," 29.

appropriately" (*Analects* 4.3). He also teaches that to be a pupil (*dì zǐ* 弟子) means "to show filiality at home, to show respect to elders when outside, to be careful and truthful in speech, to love all but to be close to persons of *rén*" (*Analects* 1.6). He thus shows preference for persons of virtue and humaneness. In Analects 17.23, when Confucius was asked whether the paradigmatic person (*junzi*) dislikes anyone, he answered in the affirmative, then explains the *junzi* "dislikes people who gossip about the misconducts of others; people who slander those in higher position; people who have courage but no propriety (*lǐ* 礼); people who get themselves into an impasse (*zhì* 窒) because of their untempered determination."[139] This understanding of *rén* as differential love is the background to Lãn Ông's instruction in the *Moral Precepts* that physicians ought to care especially for filial children and dutiful wives who fall sick because of extreme poverty (Precept No. 8). It also helps explain Lãn Ông's view that " Those who become poor and sick from reckless exploits do not deserve as much sympathy" in the same text. Within the Confucianist tradition, this differential love not only favors people who are bound to the agent by the special bonds of relationship, but also shows preference for the virtuous persons within the community. However, Confucius does not promote total rejection of wicked persons, because if such persons are willing to make amendments, he would be willing to "teach without discrimination."[140]

Yi 義 is best understood in terms of the agent's disposition and action within the

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[139]Original, "恶称人之恶者，恶居下流而讪上者，恶勇而无礼者，恶果敢而窒者。" Giản Chi & Nguyễn Hiến Lê, *Đại Cương Triết Học Trung Quốc*, [Handbook of Chinese Philosphy] (Hochiminh City: NXB Thanh Niên, 2004), 368-369.

[140] Ibid.

Five Relationship listed above.[141] *Yi* can be rendered as "right" when it is used for an act which is fitting for such relationships. When it refers to an agent who performs such acts, *yi* can be rendered as "righteous."[142] The practice of *yi* is therefore agent-relative, because the rightness of an act is determined by the agent's social role and the relevant bonds of relationship.[143] To practice *yi* often involves putting the relationship(s) above personal gains or profit (lì 利). It was Confucius who set up the contrast between righteousness (*yi* 義) and profit (lì 利) when he said, "The paradigmatic person comprehends righteousness (*yi*); the small-hearted person (*xiao ren,* 小人) comprehends profit (*lì*)" (*Analects* 4.16).[144] Subsequently, Mencius considered profit (lì 利) as the diametric opposite of humaneness (*rén* 仁) and righteousness (*yi* 義) which the good ruler ought to seek (*Mencius* 1A.1). This disparage for profit is reflected in Lãn Ông's *Moral Precepts for Physicians*, because physicians ought to act according to the dictate of *humaneness* (*rén* 仁) rather than seeking profit.[145]

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[141] For this reason, in later Confucianism (after Confucius) *yi* is often understood to reflect the particular love (or fidelity) toward those who are closer to oneself, while *ren* denotes the more universal (though graded) love for all humans. Mencius stresses *ren* and *yi* (against both Mo Tzu who insisted on universal love and Yang Zhu who insisted on self-love) so as to balance the requirements of the universal love against the particular fidelity toward one's family/clan. This to some extend mirrors the debate in the Occident regarding the right relationship between the individual and the community. In Vietnamese Confucianism, the renowned scholar and one of the founding fathers of the Later Lê Dynasty Nguyễn Trãi proposed a guiding vision for the nation based on *ren* and *yi*. Nguyễn Đăng Thục, *Lịch Sử Tư Tưởng Việt Nam* [A History of Vietnamese Thought], Vol. VI-VII (Hochiminh City, NXB Tp Hochiminh: 1992), 5-12.

[142] D. C. Lau, *The Analects,* xxvi.

[143] See Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy,118.*

[144] In the *Four Books* of Confucianism, the term "small-hearted person" (*xiao ren,* 小人) is used as the diametric opposite of the paradigmatic person (*junzi* 君子), to illustrate the vices and weakness of character.

[145] In Confucianist ethics, especially from Mencius onward, the virtues *ren* and *yi* often go hand in hand. For Confucianists, "to practice *ren yi*" is to fulfill one's moral duties. In the next section, my discussion of Lãn Ông's ethics will focus specifically on *ren*, because Lãn Ông defines medicine as the art of *ren* (humaneness). However, it seems that *yi* is implied in some of Lãn Ông's instructions on patient care,

It is not clear whether Confucius had the concept of the "cardinal virtues" in the sense that mirrors the Aristotelian-Thomistic tradition. However, it is clear that the major virtues mentioned in the *Analects* are practical virtues, and the exercise of these virtues is *agent-relative*, for it ought to be in accordance with the social role of the agent.[146] The cultivation of the virtuous character takes place through the process of learning and thinking, and the participation in other activities that constitute the good life.[147] In line with this, education aims to produce virtuous persons who can live a good life and lead others by example toward the good life.[148]

3.5.2. Lãn Ông: Medicine as the Art of Humaneness

My brief survey of Confucianist ethics aims to provide some context for the discussion of the virtues within Confucianism, particularly the medical virtues that Lãn Ông advocated. Lãn Ông's definition of medicine as the "art of humaneness" both situates his medical ethics within the Confucianist moral tradition and also specifies the fundamental value of medical practice. In his writings Lãn Ông frequently brings the reader back to humaneness, the overarching directive of medical practice. As the renowned Vietnamese Confucian scholar of the early twentieth century Trần Trọng Kim explains, within the Confucianist tradition, the training in virtue is the root, while the training in the art is the branch.[149] The root has to be strong so that the branch can be healthy. In the light of this,

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especially the physician's duty not to abandon the distressed patient, and his warning against putting profit above human lives in medical practice.

[146] Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy,* 125-126.

[147] Ibid, 128-133.

[148] Cf. ibid, 114.

[149] Trần Trọng Kim, *Nho Giáo,* 667-668. This concept has its origin in *the Great Learning* (Daxue) where

the root of medical practice is a virtuous character of the physician, whose primary task is the cultivation of humaneness. Upon this foundation, the physician is to apply the medical knowledge and skills in the service of patients, motivated by the *love for human persons* which is the essence of humaneness (cf. the *Analects* 12.22). In addition, the cultivation of humaneness in the physician is an ongoing process that takes place through (and aided by) the practice of the healing art. This organic, reciprocal relationship between the cultivation of the humane character and medical practice is explained in Lãn Ông's preface to his medical compendium. Lãn Ông insists that medical practice is more than an occupation (like farming) or a craft, and the practice ought to be called the *dao* of medicine (yī dào 醫道). Note that in this discourse the term *dao* has two levels of meaning: primarily it refers to the interior process of self-cultivation; secondarily it refers to the way one engages in one of the arts so as to serve the good of others. The secondary task is built upon the primary (self-cultivation) and helps bring it to its fruitful end. In regard to its primary meaning, James Bretzke points out that *dao* "refers to the governing vision which guides one along the path of life," and it is related to "a process in which each individual strives to actualize the potential to become a truly human person."[150] In this context, *dao* is interconnected with *ren*, because *ren* is "the fundamental virtue, but the understanding of virtue itself is related to following the *tao* of humankind."[151] In regard to its secondary meaning, Lãn Ông concedes that the common

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self-cultivation is considered the root, and the human conducts or external achievements are the branches. See Yanming An, "Daxue (Ta Hsueh): The Great Learning" in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy* (New York/London: Routledge, 2003), 232-233.

[150] James T. Bretzke, "The Tao of Confucian Virtue Ethics," 35; "Moral Theology out of Asia" in *Theological Studies*, 61(2000), 112-115.

[151] Ibid.

paradigm of *dao* in practice is the *dao* of governance. In essence, "dao" is the way leading to "order" (zhì 治). In practice, *dao* involves the moral tasks that begin with the self, then extend successively outward, "to cultivate one's person, to regulate one's family, to order one's state, to set the world at peace."[152] The usual way to practice *dao* is to become a public servant, applying one's learning and talents in the governance of the state; to set the moral standards for public life; to establish order and peace in accordance with the virtue and humaneness of the sage rulers of old.[153] This is well in line with the classic view of the Confucianist academia. According to this view, *dao* is the way, the goal of which is in "manifesting illustrious virtue, in making the people new, in abiding in the highest good" (*Great Learning*). Behind this is a particular perception of the human person and the place of human beings in the universe. The *Book of Rites* 禮記 best captures this view in the famous text,

> Humans are the virtue (*de* 德) of Heaven and Earth,
> The encounter between Yin and Yang,
> The focal point of the spirits,
> The purest forms of the Five Elements (*Book of Rites* 9.20).[154]

Because of the crucial place of human beings in the universe, to live in accordance with virtue in personal and public life is to manifest the virtue of Heaven and Earth and thus fulfilling one's role in the universe. Ordinarily, this is how *dao* is understood by the scholar. While not refuting this classic view, Lãn Ông defends a broader understanding

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[152] From the *Great Learning*, cited in Lãn Ông's preface to *Hải Thượng Y Tông Tâm Lĩnh* [The Principles and Practice of the Hải Thượng School of Medicine], 20.

[153] Ibid.

[154] *The Book of Rites*, Chapter IX Li Yun 禮運, 20, "故人者，其天地之德，陰陽之交，鬼神之會，五行之秀氣也。"

of *dao* because, as he sees it,

> The *dao* of the universe is immanent everywhere, for it permeates all things. To specify it under headings and categories is impossible simply because there will be too many to account for. There are more than one way to serve the good of society.[155]

Lãn Ông goes on to explain the correlation between Confucianist learning and medical learning, between the art of government and the medical art, and argues that "medical books, though refering to the treatment of illnesses, in fact contain in them the directives for establishing order and peace for the state." He relates his life story as an illustration of the aspiration to serve society by initially seeking public office, the aspiration which retained its full vigors as he turned to the medical art. He calls it the *dao* of medicine because it is a way – among others – which enables the practitioner to manifest virtue (*de*) through the art, to serve society while aspiring to the highest good. Also through the medical art, the practitioner continues to cultivate in virtue by committing to the moral standards of medicine in the service of the community. As the fundamental virtue of medicine is humaneness, medical practitioners manifest this virtue through humane acts in the service of patients, and continue to cultivate themselves in humaneness by adhering to the moral directives of medicine which he specifies. In this broader sense, though physicians neither hold public office nor exercise political power, they can contribute positively to the good of society through being exemplars of virtue and selfless service of others. This is closely in line with the trajectory expounded in the *Great Learning,* "The paradigmatic person (*junzi* 君子) without leaving his household can give perfect instruction for the whole state," because in being filial to his parents he shows others how

[155] Lãn Ông's preface to *Hải Thượng Y Tông Tâm Lĩnh*, 20.

to treat the ruler; in respecting his elders he shows others how to treat the governor; and in being kind to his children he shows others (rulers and governors) how to treat the people under their care.[156] For this reason, James Bretzke maintains that "in the Confucian system all ethics are always social ethics; even the private cultivation of one's inner harmony is directed ultimately at the unfolding of external social harmony."[157]

In order to fulfill the medical duties and to live out this higher calling, the physician must cultivate "humaneness" or "love of others," for it is the key virtue and the first principle of medical practice.[158] For Lãn Ông, humaneness is the necessary virtue in a physician, and those who do not possess it must not practice medicine. In his view, physicians have the duty to protect people's lives and those who are "lacking in knowledge, deceptive in conduct, deficient in diligence and courage" ought not to practice medicine.[159] Humaneness in the physician involves accepting responsibility for the care of the patient. This social responsibility requires that physicians make themselves available for service, have the remedies prepared and ready for use, and not abandon patients who suffer from critical illness. In his words, "When the patient is gravely ill, the physician must work really hard to find a cure, searching far and wide for the right remedy, finding life among the signs of death, trying one's best to save the

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[156] *The Great Learning*, Commentary on the phrase, "to order one's state one must first align one's household." See also Yanming An, "Daxue (Ta Hsueh): The Great Learning" in Cua, *The Encyclopedia of Chinese Philosophy*, 232-233.

[157] Bretzke, "*The Tao of Confucian Virtue Ethics*," 39.

[158] In this section, I am indebted to Professor Trương Việt Bình, Director of the University of Traditional Medicine, Hanoi for his valuable input, and his conference article "Một Số Vấn Đề Về Y Thuật, Y Đức, và Y Đạo của Hải Thượng Lãn Ông" [Lãn Ông's View of Medical Ethics and the *Dao* of Medicine] (Hanoi, The University of Traditional Medicine of Vietnam, 2008).

[159] Lãn Ông, Preface to "Y Âm Án" [Cases Resulting in Death] in Hải Thượng Y Tông Tâm Lĩnh, 442.

patient."[160] When there is a medical emergency, the physician ought not to refuse people's request for help, regardless of the inconvenience of long distance, of bad weather, or time of day, for "if the physician refuses patients with grave illness, what is the use of practicing medicine?"[161] Lãn Ông's directives suggest that practitioners of his time frequently refused to accept difficult cases due to concerns about reputation or profit, while showing little concern about people's lives. In his view, such behavior is unworthy of a practitioner of the humane art. Physicians must not have profit (lì 利) as their primary motive, but service out of love for others in accordance with humaneness. The commitment to humaneness also requires physicians to treat rich and poor patients equally, and to provide for poor patients from whom no significant profit can be gained.

3.5.3. Lãn Ông on the Medical Virtues

Lãn Ông names eight vices that physicians ought to avoid, and eight related virtues to be cultivated. His discourse on these virtues and vices belongs to the chapter that details twelve clinical cases under his care that resulted in patient death (*Y Âm Án*). The earnest tone used in the author's narratives at times reveals a disquiet of conscience regarding the mistakes which he has made, or the carelessness in conduct which he later regreted. Lãn Ông reports such cases to "remind myself of things to be avoided, also hoping that my colleagues will be vigilant against similar mistakes, for that will be a blessing for the medical profession."[162] At times, Lãn Ông frankly acknowledges the limits of his

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[160] Ibid.

[161] Lãn Ông, Preface to "Y Dương Án" [Cases Treated Successfully] in Hải Thượng Y Tông Tâm Lĩnh, 414.

[162] Lãn Ông, "Y Âm Án," Case 3, in *Hải Thượng Y Tông Tâm Lĩnh*, 447.

capacities, and his reason for including such cases is "to seek advice from more learned practitioners."[163] Throughout the section, there is a deep sense of Lãn Ông's commitment to the service of human lives and to medicine, the commitment that prompted him to put the good of others above personal interests in the disclosure of his own failures and errors. Lãn Ông's list of vices is a poignant reminder of the moral pitfalls that he had encountered through his medical career, or those that he had to constantly guard himself against.

Lãn Ông's list of vices include: laziness, stinginess, greed, dishonesty, inhumaneness, pettiness, impiety, and ignorance.[164] In Lãn Ông's explanation, when the physician is reluctant to make house calls, either at night or in bad weather, and thus gives treatment without seeing the patient, it is called "laziness." When the severe illness requires an expensive remedy, but the physician for fear that the patient is unable to pay, only gives a cheap remedy, it is called "stinginess." When the physician sees clearly that the patient is going to die from the illness, but hides the truth to make profit out of the

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[163] Lãn Ông, "Y Âm Án," Cases 1, 2 in ibid, 443-445. Scholars of Vietnam and other Confucian societies commonly present their opinion then ask for input/guidance from the more learned (gão míng 高明) in the art. Behind this custom (still practiced today to some extent) is the understanding that no matter how learned one has become, there are always those who are more advanced in learning and virtue that one has to listen to.

[164] Lãn Ông, Y Âm Án, Case 10 in ibid, 460. In Vietnamese, the eight vices are: lười, bủn xỉn, tham, lừa dối, bất nhân, hẹp hòi, thất đức, dốt. The seventh vice on the list, "thất đức," (shī dé 失德) is the most difficult to render in English. Literally, it means "lack of dé 德". Dé 德 in this case denotes the merit (ēn 恩) one gains as a result of a gracious act done on behalf of another. Behind this is the view that the virtuous are rewarded, and the wicked are punished, either in their own lifetime or in their descendants. "Lack of dé" (here rendered "impiety") means to act without mindfulness of such consequences. I render the corresponding virtue, "dé" as "piety." Arguably, there is parallel in Lãn Ông's thought with the concept of *eusebeia* in the Greek classics. A popular Vietnamese folk rhyme ("ca dao") says, "Cây xanh thì lá cũng xanh; Cha mẹ hiền lành để *đức* cho con." (Healthy trees produce healthy foliage; Generous parents leave "đức" *dé* to their children). For a discussion of the various meanings of *dé*, see David S. Nivison, "De (Te): Virtue or Power" in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy*, 234-235. For an overview of the law of retribution (karma) in Chinese Buddhism, see JeeLoo Liu, *An Introduction to Chinese Philosophy: Fram Ancient Philosophy to Chinese Buddhism* (Oxford: Blackwell Publishing, 2006), 209-219.

patient's situation, it is called "greed." When the physician finds an illness that can be cured easily, but says it is a grave illness to deceive people for personal gain, it is called "dishonesty." When seeing a grave illness, the physician ought to tell the truth and then try his best to save the patient. However, if the physician refuses to treat, for fear that failure will harm his reputation, or fear that no profit can be gained if the treatment fails, leaving the sick to their fate, it is called "inhumane." When the physician keeps a grudge against another person, and thus refuses to provide medical service or treats carelessly when the person is in need, it is called "pettiness." When seeing the orphan or widow, the dutiful or the filial child who is sick because of poverty, the physician turns away without providing assistance thinking his kindness will be wasted on such persons, it is called "impiety." When the physician makes mistakes because his understanding is superficial and his learning inadequate, it is called "ignorance." Corresponding to these are the eight virtues that physicians ought to cultivate: humaneness, transparency, piety, wisdom, magnanimity, sincerity, justice, and diligence.[165] Lãn Ông maintains that those who do not have these virtues should not practice medicine. He reiterates what he has taught his students, "Those who practice medicine without a generous heart, nor a deep desire to save people's lives, but are only concerned about profit to the detriment of people's lives, are no different from armed robbers."[166]

For Lãn Ông, the medical virtues/principles thus include "humaneness" (*rén* 仁, nhân) against inhumaneness, "diligence" (*qín* 勤, cần) against laziness, "piety" (*dé* 德,

[165] Ibid. In Vietnamese, the eight virtues are: nhân, minh, đức, trí, lượng, thành, liêm, cần. The virtues are listed in this order by Lãn Ông, which does not strictly correspond in order to the vices on his list. Nevertheless, the listed eight virtues

[166] Ibid, 461.

đức) against impiety, "sincerity" (*chéng* 誠, thành) against dishonesty, "wisdom" (*zhì* 智, trí) against ignorance, "justice" (*lián* 廉, liêm) against pettiness, "magnanimity" (*liàng* 量, lượng) against stinginess, and "transparency" (*míng* 明 minh) against greed. This list summarizes the moral ideals which Lãn Ông discusses in the *Moral Precepts for Physicians* and other ethics sections interposed all through his compendium. Most significant is the physician's refusal to provide medical care because of concerns for personal interests, which Lãn Ông calls "inhumaneness." This is consistent with his view of medicine as the "humane art," and its practitioners are to carry out "humane acts" in the service of others. Refusal to do so for selfish reasons is contrary to the very nature of medicine, and the violation of its fundamental ideals. For this reason, in order to practice humaneness one must overcome selfishness. Medical practice demands in the physician the altruism that transcends cost-benefit calculation, for such calculation will corrupt the virtue of "humaneness" that the physician ought to embody. The vices that Lãn Ông names are mostly vices of selfishness or greed: to attend whole-heartedly to the rich while neglecting the needs of the poor; to give priority of care according to people's wealth rather than urgency of illness; to mislead by trickery and lies regarding patient illness; to abandon patients to their fate for fear of harm to one's reputation or lack of remuneration.

A key feature of Lãn Ông's medical ethics is his sustained emphasis on professional competence. "Humaneness" demands proper respect for human lives. To practice medicine without the comprehensive knowledge of the medical science (*yī lǐ* 醫理, y lý) is called "ignorance," which he strongly condemns. Sadly, his writings suggest

that such practitioners were common during his time. He writes, "People usually make a diagnosis based on superficial observations… then treat by adhering mechanically to old remedial formulae without adequate understanding or care…when the patient's condition worsens, they blame it on fate."[167] Lãn Ông maintains that medicine is a very difficult and demanding profession, and there is no shortcut in medical training. He relates, "When I was in my 30s and 40s, I knew but a little about medicine; in my 40s and 50s, I began to make fewer mistakes in practice; not until I was in my late 50s, 60s and 70s was I free from making mistakes… that is why practicing medicine is very difficult."[168] If ignorance is a vice, Lãn Ông repeatedly emphasizes the importance of learning, as he himself has spent twenty years of labor to understand the medical art. Once the physician is in possession of the comprehensive knowledge and judgment which medicine requires, the physician can display the virtue of wisdom (zhì 智) in medical practice.

Another recurrent theme in Lãn Ông's ethical discourse is the sincerity of the physician, in the face of widespread dishonesty and fraud among practitioners of his time. Lãn Ông is acutely aware of the vulnerability of the patients and their families, who have to be dependent upon the physician because of illness. In his view, to take advantage of patient's vulnerability and dependence for personal gain is "no different from armed robbers." Lãn Ông promotes the virtue of "sincerity" *chéng* (誠, thành) which itself has its roots in Confucianist ethics and the Chinese medical tradition. Earlier, we have seen *chéng* 誠 in Sun Szu-miao's medical ethics, where it is an indispensable quality of a great

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[167] Lãn Ông, Preface to "Y Nghiệp Thần Chương" [The Essentials of Medicine] in *Hải Thượng Y Tông Tâm Lĩnh*, Vol. 1, 27. Again, "fate" is used to render (命), following Tao Lee's translation of Chen Shih Kung's text.

[168] Ibid.

physician (*dà yī* 大醫). In the Confucian Classics, *chéng* refers to the ideal state of the heart (*xin* 心) when the heart is completely directed toward the good.[169] In *The Great Learning*, to make one's will sincere (*chéng yì* 誠意) is a crucial step in the cultivation of the self for service of the family, of the state and the world (ch.1). In contrast to the wicked person who often tries to hide the wickedness within and to put on a good appearance when meeting others, the paradigmatic person is sincere in manifesting the true virtues that come from within (*Great Learning* ch. 6). In *Mencius*, *chéng* is a quality that is dependent on understanding goodness, and the key virtue for pleasing one's parents, for gaining trust from friends, for obtaining the confidence of superiors, and for the government of the people (*Mencius*, 4A.12; cf. *Doctrine of the Mean* ch. 20).[170] This text also describes *chéng* as the way (*dao*) of Heaven; to ponder upon *chéng* is the way of humans. A person of *chéng* is able to move the hearts of others, while the person without it is unable to do so.[171] In the *Doctrine of the Mean,* to be watchful over one's inner thoughts and inclinations is a crucial part of self cultivation (ch.1), which Shun believes is related to *chéng*.[172] Nguyễn Trãi (1380-1442), the renowned Vietnamese scholar and military strategist of the war of independence against the Ming domination, describes "sincere love" as the way of Heaven *and* the way of government,

> Sincere is the heart of Heaven and Earth in loving all things. Sincerely loving children is the heart of parents. Loving things without sincerity leads to obstruction in the ongoing flow of life. Loving children without sincerity leads to diminution of parental love. That is why Heaven and Earth relate to all things, parents relate to children, with

[169] Kwong-loi Shun, "Cheng (Cheng): Wholeness or Sincerity" in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy* (New York/London: Routledge, 2003), 37.

[170] Ibid.

[171] D.C. Lau, *Mencius,* 160-161.

[172] Shun, "Cheng (Cheng): Wholeness or Sincerity, " 37-38.

nothing other than sincerity (*chéng*).[173]

Chéng is the key element in the way of Heaven and Earth and the way of parenting. It is therefore the key element in the way of governing the people, whom the ruler ought to treat as his own children.[174]

Upon this background, Lãn Ông's insistence on *chéng* in the physician functions at three levels. First, *chéng* has a key role in the moral cultivation of physicians, for it undergirds their integrity and strength of character. Second, practicing *chéng* collectively would enable medical practitioners to gain the public trust, which is crucial for the viability of the profession. For Lãn Ông who insists on the social responsibility of the physician, practicing *chéng* also has a third function: to set good examples, for rulers and civilians alike, of sincere conduct, of service, and of care for the vulnerable within the community.

3.5.4. The Widows, the Orphans, and the Childless Elderly in Confucianist Ethics

Lãn Ông twice refers to the orphans, the widows, the childless elderly who require extra care and support from the physician. As is the case with most traditional societies, these are the most vulnerable persons within the community because they lack the necessary source of care and support from the family. In the case of a Confucianist society, the emphasis on the duties generated by the "Five Relationships" and the "Three Bonds" not

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[173] "Thành ư ái vật giả Thiên Địa chi tâm. Thành ư ái tử giả phụ mẫu chi tâm. Ái vật bất thành tắc sinh sinh hữu thời nhi tức. Ái tử bất thành tắc từ ái hữu thời chi tức. Thị dĩ Thiên Địa chi ư vạn vật, phụ mẫu chi ư xích tử bất quá nhất thành nhi dĩ." Nguyễn Trãi, "Dữ Vương Thông Thư" [Letter to Vương Thông] cited in Nguyễn Đăng Thục, *Lịch Sử Tư Tưởng Việt Nam* [A History of Vietnamese Thought], (Hochiminh City: NXB TP Hochiminh, 1992), Vol. VI-VII, 28.

[174] *The Great Learning* cites a verse from the *Book of Odes* to explain that in regard to the governing of the people, "Be it like tending a newborn babe" (Commentary on "Aligning one's household"). See also *Doctrine of the Mean*, ch. 20.

only helps to foster social harmony and prosperity, but at a more basic level, it also helps ensure the survival of the individual person through mutual support within the family network. However, there are also individuals who fall outside of such family networks, and cannot rely on their parents, spouse, children or sibling for support. The most comprehensible reference in Confucianist texts to these vulnerable persons is found in Mencius' answer to King Hsuan of Chi when the latter asked about government,

> Formerly, when King Wen ruled over Chi, tillers of land were taxed one part in nine; descendants of officials received hereditary emoluments; there was inspection but no levy at border stations and market places; fish-traps were open for all to use; punishment did not extend to the wife and children of an offender. Old men without wives are called *guān* 鰥 (widowers), old women without husbands are called *guǎ* 寡 (widows), old people without children are called *dú* 獨 (lone elderly), young children without fathers are called *gū* 孤(orphans) – these four types of people are the most destitute and have no one to turn to for help. Whenever King Wen put benevolent measures into effect, he always gave them first consideration. The Odes say, "Happy are the rich; but alas for the *qióng dú* 煢獨 (helpless and lone elderly)!" (*Mencius*, 1B.5).

Lãn Ông must have had in mind this passage when he wrote the text of Precept 8, in which he refers to *gū guả qióng dú* 孤寡煢獨 (the orphans, the widows, the helpless and lone elderly) to whom physicians ought to provide special care. In his discussion on social welfare in Confucian thought, Joseph Chan suggests that this text from *Mencius* can be interpreted by "a multilayer system of provision of care and help in which the family, the village or commune, and the government all play a role."[175] Within this system, the family is the first – and most important – tier of support and care for the individual person. The second tier is the network of communal relationships. In Mencius' proposed "well-field system," the basic commune consists of eight households

[175] Joseph Chan, "Giving Priority to the Worst Off: A Confucian Perspective on Social Welfare" in Daniel A. Bell and Halm Chaibong (eds), *Confucianism for the Modern World* (New York: Cambridge University Press, 2003), 238.

which can provide mutual support among their members.[176] Mencius insists that if members within this commune "befriend one another both at home and abroad, help each other to keep watch, and succor each other in illness, they will live in love and harmony." (*Mencius* 3A.3). The second tier of social support thus consists of the neighbors. The third tier of social support is the government which, as Mencius maintains, ought to give priority to those who can neither support themselves nor receive any support from family or friends: the widows, the orphans, the lone elderly.[177]

Upon this background, Lãn Ông's insistence on the deferential care for the orphans, the widows and the lone elderly further highlights the social responsibility of physicians. Mencius instructs King Hsuan of Chi to "treat the aged of your own family in a manner befitting their venerable age and extend this treatment to the aged of other families; treat your own young in a manner befitting their tender age and extend this to the young of other families" (Mencius 1A.7). In Confucianist tradition, these directives make for the good governance. In Lãn Ông's medical ethics, they also make for humane medicine.

3.5.5. Lãn Ông's Contribution to Medical Ethics: An Evaluation

Thus far in this chapter I have demonstrated that Lãn Ông's writings provide a coherent medical ethic that is grounded in Confucianist tradition, in which humaneness serves as

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[176] Mencius proposes this "jing (井) system" or "well-field system" which is primarily a method of distribution of land. Each *jing* is a piece of land measuring one *li* square, divided into nine equal plots as this ideogram suggests. The central plot belongs to the state, and the other eight plots each are held by eight families who share the duty of caring for the plot owned by the state. This explains the 1:9 rate of tax in the above passaage. *Mencius* 3A.3.

[177] Joseph Chan, ""Giving Priority to the Worst Off: A Confucian Perspective on Social Welfare," 236-241.

both the primary medical virtue and the overarching guide of physician conduct. In line with Confucianist ethics, Lãn Ông believes that the cultivation of virtue in the physician is the root, while the medical art is the branch of the human endeavor. The outstanding theme that permeates through Lãn Ông's ethics is the social responsibilities of the physician. Lãn Ông believes that, as guardians of human lives, physicians hold a vital social role, which entails a number of concrete responsibilities. Physicians ought to be diligent in learning and in their work so as to excel in their art. To perform their duties well, physicians ought to cultivate themselves in virtue. Lãn Ông's *Moral Precepts for Physicians* also provides a number of principles to guide physician conduct: physicians are to extend equal respect to all, to explain their the treatment plan carefully to patients before prescribing, to be courteous to colleagues, to care especially for the poor and the vulnerable in society, and to make themselves available for service. Lãn Ông's *Moral Precepts* both reiterates the earlier moral guidelines in the Chinese medical tradition and develops them further in a distinctive direction. In his view, the social responsibility of the physician expresses itself most clearly in the care of the orphans, the widows, and the childless elderly. As Lãn Ông defines medicine as "the humane art," this humaneness is best captured in the physician's commitment to the care of the most vulnerable in the community.

In as much as Lãn Ông's moral vision and directives deal with the fundamental values and goals of medicine, as I believe they do, their validity can transcend time and cultural boundaries. At the same time, Lãn Ông's ethics also speak to his own historical context. The widespread famine in Tonkin between 1727 and 1730 was the background of Lãn Ông's advice to physicians not to abandon starving patients to their fate, for

patients "who have medicines but no food to eat also perish" (Precept 8). It was the time when many practitioners sought profit by deception and exploitation of patient's vulnerability that Lãn Ông insisted on physician competence and sincerity, in order to establish the public trust in the medical profession. It was during the period of great social and political unrest, of numerous rural uprisings against corrupt rulers, that Lãn Ông stressed the virtues of humaneness and piety in physicians whom he believed could contribute to the good of society by setting good examples for others. It was during the period when the peasant farmers lived constantly on the brink of starvation due to high taxation in the aftermath of the drawn-out civil war that Lãn Ông insisted that humaneness at times demands that physicians provide for their patients' material needs out of their own resources. Lãn Ông's medical ethics thus brings the virtue of humaneness to bear on the concrete human predicament of his time, in his own context. His humane concern for the poor and the vulnerable however transcends his context for it touches deeply into the common needs of humans across time and culture.

It is unclear whether Lãn Ông's insistence in Precept 1 that those who learn medicine must first "master the principles of Confucianism" represents a genuine altruistic concern for physician competence in general, or alternatively a promotion of the group interests of the Confucianist physicians to which he and his disciples belonged. If the latter was the case, then Lãn Ông's assertion could serve as an affirmation that Confucianist medicine is the norm, and as a sweeping dismissal all other health practitioners and healers of his day whose practice was not based on "principles of Confucianism." It is clear that in Lãn Ông's writings there is no reference to health practitioners or healers outside of the Confucianist medical tradition, and one can

reasonably conclude that Lãn Ông indeed considered Confucianist medicine as the norm. However, it would be harder to establish that Lãn Ông was promoting group interests while dismissing the validity of rival groups of health practitioners and healers.

Another point of contention is Lãn Ông's differential love which favors the virtuous poor. While he advocates special care for filial children and dutiful wives who are poor and sick, he does not think persons who become poor and sick by engaging in reckless behaviors deserve as much sympathy from physicians. Though it can be granted that Lãn Ông's medical ethics aims to promote ethical behavior in society by showing favored treatment of the virtuous, this can also be construed as a form of judgmentalism which might be harmful in certain socio-medical circumstances, such as in the present-day fight against the AIDS pandemic. Such judgmental attitude can alienate persons who are considered "responsible" for their own illness, the attitude we see too often in regard to AIDS sufferers. As the works in this field over the last decades have shown, such discrimination simply drives the AIDS sufferers away from medical care and public awareness, and facilitates the spreading of the disease in the community without detection. On this point, the modern appropriation of Lãn Ông's view of humaneness ought to take into consideration the needs and concerns in a modern context.

Lastly, the application of Lãn Ông's *Moral Precepts for Physicians* in today's context needs to take into consideration another major concern: respect for patient autonomy. Recall that the primary concern of the Nuremberg Trials was the state of vulnerability created by the power imbalance between the physician and the patient (or research subject), and the Nuremberg move was to limit the power of physicians by emphasizing respect for patient autonomy. Lãn Ông's writings demonstrate his keen

awareness of patient vulnerability and his anguish in seeing physicians exploiting patients in their vulnerable state. Like his contemporary physician John Gregory of Scotland (1724 – 1773), Lãn Ông addressed this issue by insisting on the high moral standards of physicians, and maintaining that physicians ought to put human lives above profit.[178] Lãn Ông also made a significant contribution (Precept 5) on the importance of an adequate explanation of the treatment to patients and/or their family. According to Lãn Ông's view, this explanation ought to lead patients to greater awareness and cooperation in regard to the treatment plan. Though there is no reference to patient agreement or patient consent in his writings, Lãn Ông made a significant step toward resolving the power imbalance between physician and patient which has been the source of much abuse. Having said that, Lãn Ông's *Moral Precepts* also needs to be amended if it is to be used in today's context by including explicit reference to patient consent prior to treatment.

3.6. SUMMARY AND CONCLUSION

The reading of Lãn Ông's texts in their historical and literary context demonstrates a number of important points. First, it is apparent that Lãn Ông identified himself among the Confucianist physicians (*Rú-yi* 儒醫, Nho y). Second, his writings provide a coherent medical ethic that is grounded in the Confucianist tradition and in continuity with Chinese medical ethics. His *Moral Precepts* both reiterates the moral guidelines of

[178] See John Gregory, *Lectures on the Duties and Qualifications of a Physician,* (London: Strahan, 1772); also Laurence McCullough, 'Virtues, Etiquette, and Anglo-American Medical Ethics in the Eighteenth and Nineteenth Centuries' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 81-94.

earlier authors in Chinese medicine and develops them in a distinctive direction. Lãn Ông shows particular concern for the poor and the most vulnerable in society: the orphans, the widows and the childless elderly, and believes that physicians who provide for them will merit good fortunes either for themselves or for their descendants. Third, more than other authors of the Confucianist tradition, Lãn Ông stresses the social responsibility of physicians, whom he considers guardians of human lives. Consistent with the Confucian theory of rectification of names, Lãn Ông maintains that physicians ought to fulfill their role by displaying competence and virtue in medical practice. Furthermore, by insisting that the physician practices the *dao* of medicine (*yi-dao* 醫道, y đạo), Lãn Ông links the physician's role with the good of society. In his view, in sofar as physicians perform their role well, they can contribute positively to the harmony and flourishing of society by setting good examples of virtue and integrity for others.

Lãn Ông's medical ethics highlights a number of physician virtues which he believes are indispensible in medical practice: "humaneness" (*rén* 仁, nhân), "diligence" (*qín* 勤, cần), "piety" (*dé* 德, đức), "sincerity" (*chéng* 誠, thành), "wisdom" (*zhì* 智, trí), "justice" (*lián* 廉, liêm), "magnanimity" (*liàng* 量, lượng), and "transparency" (*míng* 明 minh). "Humaneness" is the primary virtue and the overarching principle of Lãn Ông's ethics. Because medicine is "the art of humaneness," practitioners ought to live up to this name by valuing human lives above profit, and by committing themselves to the service of patients, which often demands making sacrifices for those in medical need. In view of James Drane's emphasis on benevolence as the cardinal virtue in medicine, and Luke's

theme of mercy in Jesus' healings, Lãn Ông's view of humaneness provides an interesting point for correlative study, which is the topic of the next chapter.

Chapter IV: CHRISTIAN LOVE AND LÃN ÔNG'S VIRTUE OF HUMANENESS:A CORRELATIVE STUDY

4.1. INTRODUCTION

In Chapter One, I defended the argument that the most adequate philosophical framework for virtue-based medicine is the Aristotelian teleological structure, in which medicine is defined by its commitment to health, and virtues are personal excellences that help physicians fulfill their role in the service of a patient's health on a consistent basis. In Chapter Two I discussed Yiu Sing Luke Chan's argument that an integrated Scripture-based ethic requires both biblical scholarship and ethical hermeneutics, and my argument that the most adequate philosophical framework to serve this end is virtue ethics based on Aristotle's teleological structure. Chapter Two also engaged the healing narratives in Luke-Acts, and began the task of integrating the theological insights retrieved from Luke-Acts into the structure of virtue-based medical ethics. Chapter Three examined virtue-based medicine from a Confucianist perspective in the works of Lãn Ông, and highlighted the centrality of humaneness (*ren*) in Lãn Ông's medical ethics. My present chapter has two tasks. First, beginning with the study of the double love command in Luke, I propose a theological view of Christian health care grounded in Luke-Acts. This involves the examination of Luke's theological perspective and its significance for contemporary Christian health care. It also involves a synthesis of the insights retrieved from the Lukan healing narratives and the Aristotelian virtue-based structure in light of the works of contemporary authors previously examined in this dissertation. Second, this

chapter discusses the prospects of dialogue between Christianity and Confucianism through the correlative study of the love command in Luke 10:25-37 and the virtue of humaneness (*ren*) in Lãn Ông.

No other parable of Jesus has inspired Christians to care for the afflicted like the parable of the Good Samaritan (Luke 10:25-37). From the point of view of the current inquiry, this story brings together the key Lukan themes and connects them with the care for the afflicted: mercy, compassion, hospitality, and universality. This episode has a crucial role in Christian health ethics because it links care for the sick with the double love command which Jesus enjoins on his disciples.

4.2. THE LOVE COMMAND IN LUKE (10:25-37) AND CARE FOR THE SICK

[25] Just then a lawyer stood up to test Jesus. "Teacher," he said, "what must I do to inherit eternal life?" [26] He said to him, "What is written in the law? What do you read there?" [27] He answered, "You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbour as yourself." [28] And he said to him, "You have given the right answer; do this, and you will live." [29] But wanting to justify himself, he asked Jesus, "And who is my neighbour?" [30] Jesus replied, "A man was going down from Jerusalem to Jericho, and fell into the hands of robbers, who stripped him, beat him, and went away, leaving him half dead.[31] Now by chance a priest was going down that road; and when he saw him, he passed by on the other side.[32] So likewise a Levite, when he came to the place and saw him, passed by on the other side.[33] But a Samaritan while travelling came near him; and when he saw him, he was moved with pity.[34] He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him.[35] The next day he took out two denarii, gave them to the innkeeper, and said, 'Take care of him; and when I come back, I will repay you whatever more you spend.'[36] Which of these three, do you think, was a neighbour to the man who fell into the hands of

the robbers?"[37] *He said, "The one who showed him mercy." Jesus said to him, "Go and do likewise."*

This episode addresses the question of salvation or "inheriting eternal life" in terms of the fulfillment of the double love command, and illustrates it with the parable of the Good Samaritan.[1] In contrast to the parallel passages in Mk 12:28-34 and Mt 22:34-40 on the love commands, Luke's version is distinctive because it combines two separate commands from the Mosaic Law into one.[2] The first command from the expanded *Shema* (Deut 6:4-9) insists on the absolute love of God which involves all the faculties of the person: heart, soul, might, and mind.[3] The second command from Lev 19:18, which is part of the Holiness Code (Lev 17-26), enjoins Israelites to love their "neighbor," that is, their fellow Israelites. In Lev 19:33-34, this love is extended to the "alien who resides with you" in the land.[4] In combining the two into a single command, Luke gives "love of neighbor" the same force as "love of God," and makes it an integral part of love of God.[5]

In the Hebrew Bible, the "love of God" features significantly in the Deuteronomic writings (Deut 11:13,22; 19:9; 30:16; Josh 22:5; 23:11).[6] In Luke11:42, Jesus denounces the Pharisees for paying undue attention to trivial matters while neglecting justice and the love of God. In Luke 16:13, Jesus warns about the perils of serving both God and wealth, for "a slave will either hate the one and love the other, or be devoted to the one and

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[1] Cf. Brendan Byrne, *The Hospitality of God,* 99.

[2] Luke Timothy Johnson, *The Gospel of Luke,* 174.

[3] Fitzmyer, *The Gospel According Luke X-XXIV,* 878.

[4] Though Johnson points out that in the LXX, the "alien" is translated as *proselytos* (proselyte), thus still restricting the meaning of neighborly love. Ibid, 172.

[5] Johnson, *The Gospel of Luke,* 174. Fitzmyer, Luke X-XXIV, 878.

[6] Fitzmyer, *Luke X-XXIV,* 878.

despise the other."[7] Luke's Jesus also links forgiveness with the love of God: the one who is forgiven more has a greater capacity to love (7:42-47).[8] In the New Testament, "love of neighbor" is regarded as "the summation of the Law" (Rom 13:9; Gal 5:14; Jas 2:8).[9] As Fitzmyer sees it, the second command in the Old Testament "demands of the Israelite the same attitude toward one's neighbor as toward Yahweh himself."[10] In Luke, the double love command becomes a norm for Christian disciples so that love of God is incomplete without love of one's neighbor.[11]

Jesus' words to the lawyer, "do this, and you will live" turns the dialogue into a counsel of practice, showing the inquirer the way to "eternal life." Against the background of the Mosaic tradition, the lawyer tests Jesus with a further question about who a "neighbor" is. In response, Jesus tells the parable of the Good Samaritan who provides care for the afflicted man. The parable reflects the key Lukan themes, and also mirrors Luke's portrait of Jesus the healer. Fitzmyer rightly identifies it as one among the "parables of mercy" which give the Third Gospel "a distinctive tone and help to create a distinctive Lucan picture of Jesus."[12] The story presents an afflicted person in dire need, and the response of three passers-by. Each of the three persons *arrives at the*

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[7]Here wealth (Mammon) is personified as an idol, and the love of wealth leads to the rejection of God. Johnson, *The Gospel of Luke,* 248.

[8] Johnson stresses that in this episode of anointing (Luke 7:36-50), the love of God is not a condition for forgiveness, but an expression of the state of forgiveness. Johnson, *The Gospel of Luke,* 127-129. Also Brendan Byrne, *The Hospitality of God,* 73-76.

[9] Fitzmyer, *Luke X-XXIV,* 879.

[10] Ibid*,* 878.

[11] Ibid.

[12] Ibid, 883. Other parables of mercy in Fitzmyer's list include: the two debtors 7:41-43; the barren fig tree 13:6-9; the lost sheep 15:3-7; the lost silver coin 15:8-10; the prodigal son 15:11-32; the Pharisee and the Toll-collector 18:9-14. Fitzmyer, *Luke I-IX,* 258.

scene, *sees* the afflicted man, and *responds*.[13] This sets up a common pattern which serves to highlight the distinctive response of the Samaritan, the last to arrive on the scene. That the protagonist of the story is a Samaritan is provocative for the Judean audience upon the background of the centuries-old antipathy between Judeans and Samaritans.[14] The story told by Jesus is even more poignant against the backdrop of the Samaritans refusing to provide hospitality to Jesus and his disciples 9:51-56.[15] In contrast to the priest and the Levite who *arrived* at the scene, *saw* the wounded man and *passed by* on the other side, this hated Samaritan *arrived* at the scene, *saw* the man and was *moved with compassion* (*ἐσπλαγχνίσθη*). In Luke, "to be moved with compassion" reflects the person's character which shows itself upon *seeing* the affliction of another (cf. Luke 7:13; 15:20). With extraordinary generosity, the Samaritan performs the acts of mercy for the afflicted man: cleanses and bandages his wounds, takes him on his animal to an inn to care for him, and provides for his continued care from his own funds. The acts of mercy and hospitality performed by this Samaritan stand in sharp contrast with the law-inspired apathy of the priest and the Levite, whose single-minded devotion to their prescribed religious roles makes them insensitive to the suffering of the "sons of their own people."[16]

Jesus' concluding question to the lawyer then gives a totally new sense to the word "neighbor," and a new thrust to the conversation. It is no longer a question whether

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[13] Byrne, *The Hospitality of God,* 100.

[14] For details of the root causes of this enmity, see Luke Timothy Johnson, *The Gospel of Luke,* 162.

[15] Cf. ibid, 173.

[16] Ibid, 175. Fitzmyer, *Luke X-XXIV,* 884.

the afflicted person qualified as a "neighbor" to the three passers-by, but which one acted as a "neighbor" to the person in need. By implication, it is no longer a question about who would qualify as "my neighbor," but the command to become "a neighbor" to others through acts of mercy and hospitality. As Johnson states,

> The point, we learn, is not who deserves to be cared for, but rather the demand to become a person who treats everyone encountered – however frightening, alien, naked or defenseless – with compassion: "you go and do the same." Jesus does not clarify a point of law, but transmutes law to gospel. One must take the same risks with one's life and possessions that the Samaritans did![17]

Jesus' command to love one's neighbor illustrated by this parable resonates with his earlier instructions on love of enemy in the Sermon on the Plain (Luke 6:27-35). The Samaritan using his possessions (oil and wine, his mount, money) to assist the afflicted man reflects Jesus' numerous teachings on the right use of material possessions (Luke 3:11; 12:16-21; 14:13; 16:8a; 16:19-26; 12:42).[18] This parable also mirrors the qualities attributed to God, and to Jesus the healer as depicted by Luke. The story of the Samaritan showing mercy (ἔλεος) to an afflicted person (10:37) resonates with the Lukan theme of God's mercy (ἔλεος) shown in the unfolding plan of salvation that begins with the infancy narrative (Luke 1:50, 58, 72) and runs through Luke-Acts. It also reflects Jesus' healings of the ten lepers (Luke 17:11-19), and of the blind man at Jericho (Luke 18:35-43) who cried out to him for mercy ("ἐλέησόν"). The Samaritan being "moved with compassion" (ἐσπλαγχνίσθη) on seeing the victim resonates with the theme of God's compassion (σπλαγχνον) in Zechariah's *Benedictus* (Luke 1:78). The parable of the Lost Son (15:11-32) presents the social outcast as God's lost children, and God as the

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[17] Johnson, *The Gospel of Luke,* 175.

[18] Fitzmyer, *Luke I-IX,* 248-249.

father looks at them from afar with compassion (ἐσπλαγχνίσθη) and rejoices on their return. Similarly, Luke's Jesus was "moved with compassion" (ἐσπλαγχνίσθη) on *seeing* the sorrow of the widow of Nain (Luke 7:11-17). Being moved by the sorrow of another, Jesus responds by comforting the grieving mother, restoring her son to life and giving him to his mother. Recall that in Luke, (i) Jesus' mercy is shown most often in his outreach to afflicted persons at the margins of society; (ii) Jesus' healing ministry involves a solidarity with the afflicted persons (5:12-16), and (iii) Jesus' kindness toward his persecutor (22:47-53) reflects the non-discriminatory mercy that is attributable to God (6:35-36). These characteristics are reflected in the acts of the Samaritan, which Jesus enjoins his disciples to emulate out of love for God and for neighbors.

The Samaritan's extraordinary hospitality in the care of the victim reflects Jesus' hospitality as depicted in Luke's healing accounts. Luke's summary statements particularly stress that Jesus receives and cures *all* who come to him (4:40-41, 6:17-19). Again, the distinctive feature of Jesus' hospitality is his willingness to receive persons who are despised and cast out from society. As Jesus offers hospitality to such afflicted persons (like the leper in Luke 5:12-16), he enables society to be hospitable by receiving them back into community. In the same way, the Samaritan extends hospitality to the abandoned victim and takes him to an inn so that others can show hospitality to him. With this parable, Jesus makes mercy for the afflicted a Christian obligation, for it is linked with the double love command at the heart of Christianity. If Jesus' commissions of the disciples link healing with the proclamation of the reign of God, the parable of the Good Samaritan presents the care for the afflicted within the context of neighborly love

which is required of Jesus' disciples.

4.2.1. Mercy and Hospitality in the Context of God's Salvific Purpose

Jesus' double love command illustrated by the story of the Samaritan showing mercy and hospitality to an afflicted person takes on deeper theological significance when it is read within the broader context of God's salvific purpose as presented by Luke. As discussed in my Chapter Two, the most prominent theme in Luke-Acts is the unfolding of God's plan of salvation in fulfillment of the divine promise. The stories of Jesus' birth and life, death, resurrection, and ascension, then the birth and growth of the Church took place within an overall schema of salvation that was being fulfilled with the annunciation stories (Luke 1:5-20; 26-38). The theme of fulfillment continues throughout the life and ministry of Jesus and comes to its climax in his death and resurrection. After Pentecost, Peter in his first speech explains the gift of the Holy Spirit in terms of the fulfillment of what God has promised through the prophet Joel (Acts 2:14-36).[19] From Luke's perspective, Jesus' healing acts are to be seen within the broader context of God's salvific purpose.[20] In Luke, Jesus' audience recognizes God as the source of Jesus' healing power. After Jesus' saving interventions, the healed persons or the people, or both, give praise to God (5:25-26; 7:16; 13:13; 17:15, 18; 18:43; 19: 37). Through Jesus' healing ministry, God actively engages in bringing the promised salvation to the people.

Another major theme in Luke is the divine visitation, which Luke also links with Jesus' healings. In Luke 7:16, after Jesus' raising of the widow's son at Nain, the people

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[19] Byrne, *The Hospitality of God,* 12-13.

[20] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, *Luke,* 86-7.

glorify God and say "God has visited his people" (verb: *ἐπεσκέψατο*), which resonates with Zechariah's praises to God who has *visited* his people (Luke 1:68 *ἐπεσκέψατο*) to fulfill the promise of salvation made to Abraham.[21] In this light, Jesus comes to offer the gift of salvation through his acts of healing (8:48, 50; 17:19; 18:42), and by reaching out to the lost (7:50; 19:10). Related to the theme of visitation is the exchange of hospitality between Jesus and the persons who receive him. When Jesus who is sent by God (Luke 10:16) receives hospitality from others, he then becomes the host to welcome them into the hospitality of God. Through Jesus' healings, the hospitality of God is offered to and received especially by the poor and the dispossessed. [22] Consistent with the theme of divine visitation, salvation can be understood as an exchange of hospitality between Jesus and those who receive him. Furthermore, Jesus who has been sent by God in turn sends his disciples to extend the hospitality of God to others through their preaching and healing (9:1-6; 10:1-12). In both of his commissions, Jesus enjoins his disciples to rely exclusively on the hospitality of others as they are sent out to proclaim God's reign, emulating the same pattern of hospitality exchange in his own ministry.

From Luke's theological perspective, God's promise of salvation is fulfilled through Jesus' acts of healing and ministry to the outcast. Also from Luke's perspective, when the Christian disciple responds to Jesus' love command by showing mercy and hospitality to the afflicted, he or she *serves* God's salvific purpose for humanity. By obeying Jesus' command to love our neighbors through concrete acts of mercy, we

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[21] Johnson explains that "visit" (episkeptein) is used in the Torah to indicate God's interventions in history (Gen 21:1; 50: 24; Exod 4:31; Ruth 1:6; Ps 105:4 [Septuagint]). Luke uses it in the same sense (Luke 1:78; 7:16; 19:44; Acts 7:23; 15:14). Johnson, *Luke*, 45-6.

[22] Byrne, *The Hospitality of God,* 196.

participate in God's salvific activities in our world, and become witnesses of Jesus who showed mercy to the afflicted and the outcast. As previously discussed, through Jesus' healings God restores persons to health and to relationships. Jesus' healing acts are also concrete instances of God lifting up the lowly (1:52), gathering of the dispersed children of God (13:34), and restoring the community of God's people. In light of this, Christian disciples can serve God's saving intention by providing assistance to the afflicted and the outcast, and by welcoming them into their community. Furthermore, at the healing of the woman with a bent back (Luke 13:10-17), Jesus refers to her illness as form of bondage from which she must be released even on a Sabbath day. Her healing powerfully illustrates God's saving intention: she stood up straight and began praising God (Luke 13:13). In other healing narratives, illness and disability are associated with alienation (Luke 5:12-16; 18:35-43; Acts 3:1-10). After regaining his sight, the man of Jericho followed Jesus, *glorifying* God (Luke 18:43), and the man healed at the Beautiful Gate entered the temple with the apostles "*walking and leaping and praising God*" (Acts 3:8). In response to Jesus' command, we are to reach out and serve our neighbors who are in bondage or suffer alienation due to illness or disability, so that they too can be lifted up and praise God as part of the community.

If the story of the Good Samaritan is a "parable of mercy," its diametric opposite is the parable of the rich man who closes his eyes to the afflictions of Lazarus at his gate (Luke 16:19-31). Luke presents sharp contrasts between the two narratives. The Samaritan is "moved with compassion" for the afflicted man while the rich man remains insensitive to Lazarus' suffering. The Samaritan makes use of his possessions generously to aid a person in need while the rich man dresses himself extravagantly and feasts

sumptuously as Lazarus lies hungry and "covered with sores." The story of the Samaritan illustrates the path to "eternal life" while the rich man goes to Hades after his death. The story of the Samaritan "showing mercy" to the afflicted person is contrasted with the story of the rich man refusing to assist Lazarus during his life yet crying out to Abraham for mercy ("ἐλέησόν με") when it is already too late (Luke 16:24 cf 13:25-28). From Luke's perspective, the path to life requires acts of mercy and hospitality in the service of those in need, for God gives generously to those who are generous to others. As Jesus puts it, "the measure you give will be the measure you get back" (Luke 6:38).

The inclusive love that Jesus illustrates with this parable also reflects the evolving theme of universality in Luke-Acts. Recall that Luke's infancy narrative presents God's plan of salvation in terms of God's faithfulness to the promises made to Abraham and his descendants. In this context, God's mercy and steadfast love is understood within the structure of God's covenant relationship with Israel. The evangelist then leads the reader toward an inclusive view of God's mercy with Jesus' inaugural address at Nazareth (Luke 4:16-30), where Jesus makes reference to the prophets Elijah and Elisha who ministered to non-Jews. Luke's Jesus then reaches out to bring healing to the Samaritan (17:12-19), the Gerasene man (8:26-39), and member of a centurion's household (7:1-10). In Acts, the good news is proclaimed to Samaritans (8:4-13), to the Ethiopian eunuch (8:27-39), and in the cities of Lydda and Joppa (9:32-43) in fulfillment of Jesus' prophetic commission (Acts 1:8).[23] Luke also reports the development in the Church's understanding of God's mercy with Peter's preaching to the household of Cornelius

[23] Johnson, *Acts,* 16.

(10:34-48), followed by the mission to the Greeks in Antioch, and the campaigns of Paul and his companions (Acts 12-13). From Luke's perspective, the infancy narrative locates God's salvific plan within the context of God's fidelity to Israel. Subsequently, Jesus' healing ministry reflects a more inclusive view of God's mercy. In the post-Easter era, God's mercy has no bounds, for Jesus sends his disciples to proclaim repentance and forgiveness of sins "to all nations" (Luke 24:47; Acts 1:7-8). Consistent with the evolving theme of universality in Luke-Acts and the expanding view of God's mercy, Jesus commands his followers to "go and do likewise," that is, to show mercy to all those in need without discrimination. Jesus' double love command which involves special care for afflicted persons without discrimination reflects the universality of God's salvific purpose in Luke-Acts.

4.3. A BIBLICAL THEOLOGY OF CHRISTIAN HEALTH CARE

Into the twenty first century, care for the poor and the sick has remained central to the Church's mission. Yet, continued effort is required to articulate a theology of health care that closely reflects the gospel message and the distinctiveness of the Christian ministry. Three decades ago, the works of Alasdair MacIntyre and of Stanley Hauerwas highlighted the crucial link between narrative, community, and the virtues.[24] Hauerwas rightly emphasized that Christian ethics ought to maintain a strong connection with its

[24] Alasdair MacIntyre, *After Virtue* (Notre Dame, Ind.: University of Notre Dame Press, 1981/2007). Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic* (Notre Dame, Ind.: University of Notre Dame Press, 1981); *Character and the Christian Life: A Study in Theological Ethics* (Notre Dame, Ind.: University of Notre Dame Press, 1975/1985); *The Peaceable Kingdom : a Primer in Christian Ethics.* (Notre Dame, Ind. : University of Notre Dame Press, 1983); *Vision and Virtue: Essays in Christian Ethical Reflection,* (Notre Dame, Ind. : University of Notre Dame Press, 1981).

core narrative: the gospel of Christ.[25] The gospel is the foundational narrative which provides the vision and directives for Christian formation and decision making. In his 2005 book on scripture-based health ethics, Allen Verhey stresses that medicine ought to be kept in its (modest) place, and warns against putting "extravagant and idolatrous expectations" on medicine, because God alone is the overriding good that deserves our total trust.[26] The theological perspective is crucial in health care because it helps to keep in check those idolatrous tendencies, and helps to cultivate the right attitudes concerning health and suffering. As Verhey sees it, "The sort of dominion that keeps faith with God the creator and provider will be more care-taking than conquering, more nurturing than controlling, more ready to suffer patiently with nature than to lord it over and against nature."[27] Verhey stresses the role of the faith community in the formation of Christian disciples in light of the gospel, and in the discernment on bioethical issues. Verhey believes that reading scripture prayerfully in a community can lead to the encounter with God's good future which in turn inspires hope and provides guidance for the life of discipleship.[28]

In his insightful 2010 book, Frederick Gaiser demonstrates the way scripture can

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[25] Allen Verhey also calls for a more vigorous engagement with Scriptures in the discernment of biomedical issues. Allen Verhey, *Reading the Bible in the Strange World of Medicine*, (Grand Rapids, Mich.: W.B. Eerdmans Pub. Co, 2003).

[26] Allen Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids/ Cambridge: Eerdmans Publishing: 2003), 60. See also Marilyn Martone's review of Reading the Bible in the Strange World of Medicine in
Theological Studies, March, 2005, Vol.66(1), 214-216.

[27] Verhey, *Reading the Bible in the Strange World of Medicine*, 286.

[28] Though Verhey does not explicitly name virtue ethics as his theoretical framework, his concerns for community, moral character, and the vision of the good life are much in line with the key aspects of virtue ethics.

inform, or even more, transform health care practices.[29] From his exegetical work, Gaiser offers a theological perspective for Christian healing ministry, and highlights the spiritual richness of the health profession when medical practice is aligned with God's salvific intention for the world. In his review of Gaiser's work, Walter Brueggemann applauds his effort "to reframe our thinking and talking about healing as a counter to positivistic notions rooted in scientism."[30] Similar to Verhey's work, Gaiser's theological view helps provide perspective and direction to medical work which sadly has been dominated by scientism and institutional demands. It helps expand the horizons of Christian health practice by bringing into view the sacred dimension of the work of healing in which physicians are invited to participate. Moreover, Gaiser also reminds us that "healing depends on lively face-to-face communities of candor and hope that specialize not in cure but in healing" and that "the most likely matrix of well-being" is to be found in the "networks of neighborliness" provided by the faith communities.[31]

The works of these authors highlight the crucial role of the theological perspective in health care because it helps guard physicians against idolatrous and dehumanizing tendencies that are endemic in medical practice.[32] The theological perspective reminds physicians of the rightful place of medicine within the vast horizon of God's future that

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[29] See Frederick Gaiser, *Healing in the Bible: Theological Insight for Christian Ministry*, (Grand Rapids: Baker Academic, 2010), chapter 14, 246.

[30] Walter Brueggemann, review Gaiser's *Healing in the Bible: Theological Insight for Christian Ministry i*n *The Christian Century*, April 18, 2012, Vol.129(8), 36-38.

[31] Ibid.

[32] The debate on the end-of- life care provides good illustrations of many of these tendencies. See Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (Washington, D.C.: Georgetown University Press, 1993, 2000); *Setting Limits : Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987/1995); *False Hopes : Why America's Quest for Perfect Health is a Recipe for Failure* (New York : Simon & Schuster, 1998); Randall J. Curtis & Gordon D. Rubenfeld (eds), Managing Death in the Intensive Care Unit: The Transition from Cure to Comfort (New York: Oxford University Press, 2001).

cannot be brought under human control. Continued effort is indeed required to articulate a theology of health care that closely reflects the gospel message in today's context. As Gaiser points out, one's theology and one's health are interrelated because "good theology contributes to good health; bad theology can lead to death."[33] For medical practitioners, good theology contributes to good medicine, while the absence of it often leads to idolatry. With this in mind, let us now turn to Luke's theological perspective and its implications for Christian health care.

4.3.1. A Continuation of Jesus' Healing Ministry

In Luke-Acts, the link between Jesus' healing ministry and that of the disciples is found in two accounts of Jesus commissioning his disciples to proclaim God's reign and to heal (9:1-6; 10:1-12). Furthermore, at the Great Commission, the disciples are sent by the risen Christ to be his witnesses in Jerusalem, in all Judea and Samaria, and to the ends of the earth (Luke 24:46-49; Acts 1:7-8). Within the narrative structure of Luke-Acts and through Luke's depiction of the role of the Holy Spirit, the disciples are empowered and commissioned to continue Jesus' mission on earth.[34] Note that in Luke-Acts, the birth and growth of the Church and her evolving mission to the nations are understood as part of God's schema of salvation that began with the annunciation stories (Luke 1:5-20; 26-38). If Jesus' healing acts are to be seen within the broader context of God's salvific

[33] Gaiser, *Healing in the Bible,* 14.

[34] For further discussion on the link between Jesus' mission and the Church's mission, see Donald Senior, "The Mission Perspective of Luke-Acts" in Donald Senior & Carroll Stuhlmueller, *The Biblical Foundations for Mission* (Maryknoll, New York: Orbis Books, 1983), 255-276.

purpose for humanity, [35] so too is the Church's ministry to the sick and the afflicted in Jesus' name. The author of Luke-Acts also links Jesus and his disciples in a *prophetic succession* as was the case of Moses and Joshua (Deut 34:9); or Elijah and Elisha (2 Kgs 9-14).[36] In this light, the Church's health care ministry is a continuation of Jesus' outreach to the afflicted, the handicapped and the marginalized in fulfillment of God's promise of salvation. Christian services to the outcast in Jesus' name can embody Jesus' ongoing mission of proclaiming the good news to the poor, setting the captives free, giving sight to the blind, and proclaiming the era of God's acceptance (Luke 4:18-21). Drawing from Luke's theological perspective, I believe that Christian health care should be perceived as part of the Church's mission to serve God's salvific purpose for humankind. Christian health care is to reflect the mercy and hospitality attributable to God, and embodied by Jesus the healer, which he also asks of his disciples through the parable of the Good Samaritan. Luke's theological perspective can help guard physicians against idolatrous tendencies in medical practice, and enrich the medical acts performed in the service of the afflicted by aligning them with God's salvific purpose for humankind. If the Church as a whole is the continuation of Christ's presence and ministry on earth, Christian physicians have a unique role in the Church's ministry to the sick through which Christ continues to heal and save. Just as Luke refers to God's visitation of the people through Jesus' healings (7:16), so is today's medical consultation the occasion for the divine visitation through the physician's acts of mercy and hospitality in conformity to Jesus the healer. In light of Luke's view, God is actively

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[35] Tannehill, *The Narrative Unity of Luke-Acts,* Vol. 1, *Luke,* 86-7.

[36] Luke Timothy Johnson, *Acts of the Apostles,* Sacra Pagina Series, Vol. 5, Daniel J. Harrington (ed), (Collegeville, MN: The Liturgical Press, 1992), 14.

engaging in bringing salvation to God's people through the Church's mission, Christian physicians are well positioned to serve God's salvific purpose for afflicted humanity. As Luke presents Jesus' healing ministry as the dawning of a new era in which God's reign became manifestly present in our world, the Christian physician's loving services to the sick can also reflect God's saving intention for humanity. As Jesus reached out beyond ethnic and social boundaries to bring healing and new life to the Samaritan (Lk 17:12-19), the Gerasene man (Lk 8:26-39), a member of a Roman's household (Lk 7:1-10), so are Christian physicians called to serve patients without discrimination.

Above all, Christian physicians who aspire to imitate Jesus the healer must be committed to the service of the poor and the marginalized in society. Luke's Jesus frequently intervenes on behalf of the poor and the outcast, often by defending them against those in positions of power (Luke 13:10-17; 14:1-6),[37] so are Christian disciples called to serve the downtrodden and to be their advocates. The repeated pattern of reversal in Luke suggests that Jesus' good news not only challenges personal attitudes and behavior, but also exposes the social structures of injustice and exclusion against which God intervenes on behalf of the oppressed.[38] At his inauguration address in Nazareth (4:14-30), Jesus accentuates the *release* of captives, the theme which is echoed in Jesus' healing ministry (Luke 13:11-17, 14:1-6). In Luke's view, spiritual release must involve radical transformations including the reordering of the socio-economic structures of society. Furthermore, in light of the universal theme in Luke-Acts, God's mercy is to

[37] Tannehill, *The Unity of Luke-Acts,* Vol. 1, 103.

[38] Ibid, 109.

reach out to the poor and oppressed of all nations.[39]

As discussed in Chapter Two, the healing of the leper in Luke 5:12-16 captures many distinguishing features of Jesus' healing acts. By extending his hand and touching this marginal man, Jesus shows not only mercy in the face of social prejudice and exclusion but also his solidarity and complete care for the afflicted person: he restores him to health, to relationships, and to participation in community life. This account is a concrete instance of God lifting up the lowly (Luke 1:52), gathering the dispersed children of God (Luke 13:34), and restoring the community of God's people. The exemplary pattern of Jesus' healing ministry is then repeated in Acts by the apostles who heal in Jesus' name (Acts 3:1-10; 14:8-18). Furthermore, as Jesus was anointed by the Holy Spirit for his mission (Luke 3:21-22, cf. 4:18-19), so are the disciples empowered at Pentecost by the same Spirit to continue the salvific mission entrusted to them by the risen Lord (Luke 24:47-48, Acts 1:8). Luke's theological perspective reminds Christian physicians of God's salvific purpose for human persons, which includes not only physical and psychological health but also right relationships with self, with God, and with others in community. Luke accents the relational dimension of illness and of healing, and Jesus' special love for the poor and the marginalized. Luke's theology reminds us of God who intervenes on behalf of the destitute and calls us to challenge the unjust structures of our world that alienate and dehumanize God's children.

4.4. HEALING IN LUKE AND VIRTUE-BASED MEDICINE

[39] Johnson, *Luke,* 82. Byrne, *The Hospitality of God,* 51-52.

Thus far, we have examined Luke's healing narratives and the double love command, and discussed their ethical implications for Christian health care. This section offers a synthesis of the theological insights retrieved from Luke-Acts and the structure of virtue ethics in light of the works of Justin Oakley and Dean Cocking, James Drane, Joseph Kotva, and William Spohn that I have discussed throughout this dissertation. In Chapter Two I demonstrated that the Lukan healing narratives are congruent with the structure of virtue ethics and well in line with the *imitation of Christ* motif that Richard Burridge accents in his recent works. If Luke presents Jesus' healing acts as the restoration of persons to health and to relationships, as well as instances of God's lifting up of the lowly, and the gathering of God's children, the evangelist also provides in Acts accounts of the disciples performing healing acts in conformity with this exemplary pattern. Luke also attributes a number of virtues to God *and* to Jesus the healer: *mercy*, *compassion*, and *hospitality*. These same virtues are reflected in the parable of the Good Samaritan which Jesus enjoins his disciples to imitate by means of concrete service to the afflicted. I believe the theological insights from Luke-Acts can further enrich our understanding of virtue-based medicine in today's context.

Recall that Oakley and Cocking elucidate Aristotle's concept of the human *telos* in terms of the interlocking web of intrinsic human goods (such as courage, integrity, friendship, and knowledge) that we need for living a good life.[40] The exercise of these virtues and activities under the guidance of prudence is partly constitutive of the human *telos*. One such intrinsic human good is health, because health is central for a good

[40] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, (Cambridge: Cambridge University Press, 2001), 15.

human life. Following Aristotle, the authors define the medical profession in terms of its commitment to health.[41] This commitment determines both the physician's role and the medical virtues that enable physicians to meet the goal of serving the health of patients.[42] A virtue ethic built on Luke's theological perspective would eschew any *individualistic* conceptions of the human *telos*, for God's intention for humanity includes not only physical and psychological health, but also the right relationships with self, with God, and with others, as well as participation in community life. In light of Luke's healing narratives, Christian health care ought to be defined in terms of its commitment to health understood in this holistic sense, because along with physical and psychological health, right relationships and community life are also indispensable parts of human flourishing. This commitment defines the goals of Christian health care,[43] and determines the medical virtues that enable Christian physicians to better serve the holistic health needs of patients. In light of Luke's view of health and healing, the virtues of respect, friendliness, justice, and religion in Drane's list of virtues are particularly relevant in the holistic care for the person.

In Kotva's Christocentric virtue theory, Jesus is identified with the *telos* of human life. Kotva holds that sanctification in Christian doctrine is "a teleological concept" that

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[41] Ibid, 74. Cf. Aristotle, *Nicomachean Ethics* I.i.109a8.

[42] Ibid, 92-93.

[43] The contemporary division of labor tends to assign more specific roles to physicians, while care for the social or relational needs of patients is more commonly assigned to the social worker, the counselor, and the spiritual/ religious needs to the chaplain. For this reason, physicians tend to see their role within a more restricted sense. In addition, medicine is not the only profession defined by its commitment to the goals of health care, because other health workers and allied health workers also share with physicians these goals and responsibilities. Nevertheless, I believe physicians who pay adequate attention to the social, relational and spiritual aspects of health and of illness are far more effective in restoring patients to health.

involves personal transformation into the image of Christ.[44] To be Christ-like is the goal of the process of sanctification. In his view, the structure of sanctification (or the Christian *telos*) is *conformity to Christ*, and its content is Jesus who can be encountered in the New Testament.[45] In this light, Jesus the healer is the exemplar for Christian physicians, and his healing acts have a normative significance for Christian health care based on the imitation of Christ. For Christian physicians, sanctification is *conformity to Jesus the healer* by imitating his examples and his virtues in the present day context under the guidance of the Holy Spirit. As also discussed in Chapter Two, Luke-Acts adds a theological dimension to the *imitation of Christ* motif. As Johnson puts it, "Luke saw the work of the Holy Spirit as the replication in the lives of believers of the messianic pattern enacted first by Jesus."[46] Again, Luke's emphasis on the social dimension of healing and of mission would rule out any individualistic conception of virtue and sanctification, for the faithful are transformed and sent on mission *for* and *with* others. At the theological level, the primary agent is the Holy Spirit who is constantly at work within believers through faith to transform them into the pattern of Jesus so as to be the *continuation* of his presence and ministry on earth.

Also in line with the structure of virtue ethics, Spohn maintains that Jesus Christ is the paradigm for Christian moral life,[47] and he highlights the practices by which

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[44] Joseph J. Kotva, *The Christian Case for Virtue Ethics*, (Washington D.C.: Georgetown University Press, 1996), 93.

[45] Kotva, *The Christian Case for Virtue Ethics*, 87.

[46] Luke Timothy Johnson, *Acts,* 1.

[47] William C. Spohn, *Go and Do Likewise: Jesus and Ethics*, (New York/London: Continuum, 2003), 1, 120-128, 186. Also Spohn, "Jesus and Moral Theology" in James Keating (ed), *Moral Theology: New Directions in Fundamental Issues*, (Mahwah, NJ: Paulist, 2004), 29-37.

Christian disciples are to be transformed in accordance with the pattern of Jesus. Through engaged reading of the Scriptures, Christians come to know Jesus and become transformed by his story. Spohn pays particular attention to the role of biblical images and stories in the shaping of moral dispositions and character. Through the *analogical imagination*, these stories become for us "affective paradigms for moral dispositions," which enable us to respond in ways consistent with the story of Jesus and appropriate for our particular situation.[48] Through prayerful reflection, the stories of Jesus' encounter with persons in the Gospel become windows into the life of Christ and his first disciples, and also mirrors that reflect back on our own life of discipleship. In this light, the stories of Jesus' healings provide the "affective paradigms" for Christian physicians that play a crucial role in the shaping of their moral dispositions. Through the spiritual practices of prayer and meditation upon the biblical texts, we enter into the world of Jesus, and let Jesus enter into our world and shape our character. With the use of the analogical imagination, we recognize that as Christian disciples we are constantly called anew to identify and serve "the poor" of our time.[49] As Jesus reached out to touch and heal the leper (Luke 5:12-16), Christian physicians are called to serve and stand with those who are despised and excluded by society, so as to restore them to health and to participation in community life. The story of Jesus healing the woman with a bent back (Luke 13:10-17) reminds us that physical or mental affliction can be a form of bondage from which persons need to be released so that they can stand up straight and live as God's children. By speaking out in her defense against criticism, Jesus overthrows the unjust social

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[48] Spohn, *Go and Do Likewise,* 186.

[49] Ibid.

structures that keep people in diminishment and bondage, reminding Christians of their social responsibility especially in the care and defense of the most lowly and vulnerable in society. The story of Jesus' healing the blind man of Jericho (Luke 18:35-43) invites us to reach out to persons with disabilities who often suffer marginalization and have limited access to the goods of society. It also reminds Christian physicians of the need for ongoing conversion so as to *see* the afflicted with compassion, and *to be neighbor* to those in need through acts of mercy and hospitality. Finally, in healing the servant of the high priest who came to seize him by force (Luke 22:47-53), Jesus showed a concrete example of the non-discriminatory love which he had asked of his followers (Luke 6:27), and reminds Christian physicians of the personal costs in the works of mercy and hospitality in conformity to Jesus the healer.

4.4.1. Love of Neighbor as the Basis of Christian Health Care

From Luke's theological perspective, God's salvific purpose for humanity is the basis of the Church's mission. I believe that God's salvific purpose ought to also be the basis of Christian health care. We have examined the way Jesus' healing acts in Luke are concrete instances in which God's saving intention for humanity is fulfilled. For Luke, God's gift of salvation encompasses the whole person, for it includes the restoration of the person to physical and mental health, to relationships with self, with God and with others in community. This emphasis on healing is reflected in Luke's accounts of Jesus commissioning his disciples (9:1-6; 10:1-12). Equally important is Jesus' double love command which requires Christian disciples to love God with all the faculties of their person and to love their neighbors as themselves. To love God also means to love God's

saving intention for humankind, and to commit oneself to the service of God's purpose for humanity.[50] This is supported by the fact that Luke puts love of God and love of neighbor together in a single command, so that love of neighbor is inseparable from love of God.[51] To love neighbor as oneself involves the concrete works of mercy and hospitality to the afflicted following the example of the Good Samaritan in Jesus' parable.

If God's salvific purpose is the basis of Christian health care, Christian love – originated from the double love command and the Good Samaritan story – ought to be the fundamental value of Christian health ethics. Recall that in Drane's virtue-based medical ethics, benevolence is the cardinal virtue which provides the *hinge* for other medical virtues. In Drane's virtue theory, benevolence corresponds to the principle of beneficence, which has its roots in the Hippocratic tradition. Beneficence, which refers to the way physicians ought to use their knowledge and skills in patient care, has remained the basis of Western health care since the days of the Hippocratic physicians. In the contemporary context, this mandate is specified in the principles of beneficence and non-maleficence, while the principle of respect for autonomy keeps the physician's obligation to "do good" in check. For Christian health care informed by Luke's theological view, the fundamental value from which all ethical directives are derived is *love*: love of *God* and love of *neighbor*. This love is the basis of the Christian

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[50] Jackie A. Wyse stresses that in the Jewish understanding of the Shema, the Hebrew biblical text behind the love commandment in Luke, obedience to YHWH's commands is "an expression of love for God who has been and continues to be the people's deliverer." Jackie A. Wyse, "Loving God as an Act of Obedience" in Perry B. Yoder (ed), *Take This Word to Heart: The Shema in Torah and Gospel* (Elkhart, Ind.: Institute of Mennonite Studies; Scottdale, Pa.: Herald Press, 2005), 11-51.

[51] See Jeff T. Williams, "Love of God and Neighbor in Luke's Gospel" in ibid, 71-99.

commitment to the service of the afflicted in view of God's salvific purpose for humanity.

4.4.2. Luke's Theological Perspective and Access to Health Care

On the basis of Luke's view of physical healing as an integral part of God's gift of salvation, and illness as a form of *bondage* or diminishment which ought to be subjected to God's saving activity, I believe that Luke's theological vision can empower, or even demand, Christians to work for structures that ensure access to health care for all. Recall that James Drane understands justice in terms of the *physician's obligations* to the wider society.[52] This resonates with William F. May's emphasis on the doctor's indebtedness to society as a basis for the covenant relationship between the doctor and the wider community.[53] Drane believes doctors have a privileged position within society because of their specialized knowledge and capability. Within a contemporary knowledge-driven society, doctors ought to be aware of the power that they exercise – or can exercise – and the social responsibility associated with it.[54] In Drane's view, the virtue of justice is derived from the social dimension of the doctor-patient relationship, but ultimately it is rooted in the nature of the human person. Human beings need certain basic goods, one of which is health, in order to maintain their dignity. This is in line with David

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[52] See my Chapter One, section 1.2.1.1. James Drane, *Becoming a Good Doctor,* 94-98. Most often, bioethicists discuss justice in health care in terms of distributive justice, and how various theories of justice can influence the way we interpret just distribution of care. See for instance Beauchamp and Childress, *Principles of Biomedical Ethics* 5th ed, 225-282; Allen Buchanan, "Justice: A Philosophical Review" in Earl E. Shelp (ed), *Justice and Health Care*, (Dordrecht/Boston/London: Reidel, 1981), 3-22.

[53] William F. May stresses that, because of the physician's indebtedness to society, there is an implicit 'covenant' that the doctor enters into for service to the community. See, "Code, Covenant, Contract, or Philanthropy" in *The Hastings Center Report*, Vol. 5, No. 6 (Dec., 1975), 29-38.

[54] Ibid, 104.

Hollenbach's view that "respect for persons and their dignity requires securing basic levels of subsistence, meeting other bodily needs such as the requirements of basic health, and the protection of persons through respect for their bodily integrity."[55] This is also consistent with Luke's view of God's purpose for humanity, of which physical and psychological health – along with right relationships and community life – is an indispensable part. Luke's emphasis on the *inalienable* dignity of the human person would lend support to social structures that ensure more equitable access to care.[56] In his defense of the woman who has suffered from a bent back, Jesus refers to her as "a daughter of Abraham," therefore heir to God's promise of salvation (Luke13:16). Similarly in 16:19-31, the poor and afflicted man Lazarus who had no status in life is taken to Abraham after his death where he receives the consolation that he deserves.[57] In addition, the double love command given by Luke's Jesus, which is illustrated by the Good Samaritan story, demands that Christians actively engage in works that ameliorate the plight of the afflicted. In light of Drane's point on the privileged position of physicians, Christian physicians are not only required to attend to the sick poor when such occasions arise, but also to work for structural changes that ensure no afflicted person is abandoned due to their inability to pay. As Jesus the healer stands in solidarity with the poor (Luke 5:12-16), reaches out to lift up the lowly (Luke 13:10-17), and restores the blind beggar of Jericho to health and community (Luke 18:35-43), Christian

[55] David Hollenbach, "Human Dignity: Experience and History, Practical Reason and Faith" Paper delivered at the Conference on Understanding Human Dignity, the University of Oxford, 26-29 June, 2012, 13.

[56] See my Chapter Two, section 2.5.2.

[57] Other references in Luke include the parable of the Lost Son (15:11-32) which presents the social outcast as God's lost children; 19:9 where Jesus refers to Zacchaeus as a "son of Abraham," and locating him firmly in the realm of God's mercy.

physicians are called to attend to the health needs of the least advantaged of society so as to continue Jesus' mission on earth.[58] The next chapter on Vietnam's Catholic AIDS care network will demonstrate the connections between personal virtues, the faith community that bears witness to Jesus the healer, and action for social justice in the context of health care.

I will now summarize the arguments so far. In Chapter Two I discussed Yiu Sing Luke Chan's argument that Scripture-based ethics requires both biblical scholarship and ethical hermeneutics, and my argument that Aristotle's teleological structure is the most adequate framework to serve this end. In light of Chan's position, my Chapter Two engages the relevant texts and key themes from Luke-Acts and examines their implications for Christian health care. The second task is to integrate the theological insights from Luke-Acts into the structure of virtue-based medical ethics. In Chapter Two and the present Chapter, I argue that Luke's theological insights are congruent with the teleological structure of virtue ethics, and consistent with the *imitation of Christ* motif. In addition, Jesus' double love command in Luke illustrated by the Good Samaritan story further highlights the *exemplary nature* of Jesus' healing acts, and links Christian love with concrete acts of mercy and hospitality in service to the afflicted. For this reason, Christian love ought to be the fundamental value of the virtue-based structure

[58] The Catholic Bishops of the United States, "Forming Consciences for Faithful Citizenship: A Call to Political Responsibility" November 2007 [25] states "The moral imperative to respond to the needs of our neighbors—basic needs such as food, shelter, health care, education, and meaningful work—is universally binding on our consciences and may be legitimately fulfilled by a variety of means. Catholics must seek the best ways to respond to these needs." The document cites Pope John XXIII, "[Each of us] has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and, finally, the necessary social services" (*Pacem in Terris*, no. 11). In his speech to Catholic health workers on November 17, Pope Benedict XVI maintains that health care ought to be accessible to all, not just for those who could afford it. See http://www.catholicnews.com/data/stories/cns/1204884.htm, accessed December 3, 2012.

of Christian health ethics, while God's salvific purpose is the mandate for Christian health care. Within this structure, mercy and hospitality are the distinctive virtues of Jesus the healer as depicted in Luke's healing narratives. As also discussed in Chapter Two, mercy and hospitality were also the defining virtues of early Christianity and of early Christian health ethics.[59] The parable of the Good Samaritan grounds these virtues in the love command which Jesus requires of his disciples. It is through acts of mercy and hospitality in service to the afflicted that Christian disciples may inherit eternal life, reflect the qualities of their merciful Father (Luke 6:36), and become witnesses of Jesus the merciful and hospitable healer (Luke 24:44-49, Acts 1:7-8).

4.5. THE VIRTUE OF HUMANENESS IN LÃN ÔNG'S MEDICAL ETHICS

If Christian love is the defining value of Christian health ethics in light of Luke-Acts, *ren* (仁, humaneness) is the defining value in Lãn Ông's medical ethics. As discussed in my Chapter Three, *ren* is a key concept in Confucianism. In Lãn Ông's medical ethics, *ren* is understood as both the goal of self-cultivation and the commitment to the good of patients through medical service. According to Lãn Ông, because medicine is defined as *ren shu* (仁術, the art of humaneness), medical practitioners should perform their professional role diligently and fulfill their social responsibilities so as to be worthy of that name. This section recapitulates and further clarifies certain aspects of *ren* in Confucianism, and in Lãn Ông's writings. It is then followed by the correlative study of

[59] See Section 2.6.2.

Luke's view of Christian love and *ren* in Lãn Ông's medical ethics.

4.5.1. Humaneness in Confucianism

In an influential article, Wing-Tsit Chan identifies *rén* 仁 as the central theme of Confucius' conversations: it appears 105 times, and is the subject matter of 58 out of 499 chapters of the *Analects*.[60] In the *Analects*, *ren* is understood in both the narrow sense and the broad sense. In its narrow sense *ren* connotes a particular virtue which Chan translates as "benevolence" (*Analects* IV. 2; VI. 21; IX. 28 cf. XIV. 30; XV. 32; and XVII. 8).[61] In its broad sense, *ren* is considered the perfect virtue or the summation of all virtues. In most of his references to *ren* in the *Analects*, Confucius used the word in this broad sense. Chan explains,

> *jen* connotes the general meaning of moral life at its best. It includes filial piety (XVII.21), wisdom (V.18), propriety (XII.1), courage (XIV.5), and loyalty to government (V.18; XVIII.1); it requires the practice of "earnestness, liberality, truthfulness, diligence, and generosity" (XVII.6); it is more than the "refraining from love of superiority, boasting, resentment, and covetousness" (XIV.2); and it underlies ceremonies and music (III.3). It consists in "mastering oneself and returning to propriety" (XII.1). One who is "strong, resolute, simple, and slow in speech is near to" but still falls short of *jen* (XIII.27). A man of *jen* is respectful in private life, earnest in handling affairs, and loyal in his association with people" (XIII.19), "serves the most worthy among the great officers and makes friends of the most virtuous among scholars" (XV.9), and is cautious and slow in speech (XII.3).[62]

In line with this, Tu Wei-ming defines *rén* as "the virtue of the highest order in the value

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[60] Wing-Tsit Chan, "The Evolution of the Confucian Concept *Jên*" in *Philosophy East and West*, Vol. 4, No. 4 (Jan., 1955), 295-319. Note that Chan uses "jen" which is the older Wade-Giles Romanized form of the ideogram.

[61] Ibid, 297. Chan follows James Legge in translating *ren* in this sense as "benevolence."

[62] Ibid, 298. Following Chan's lead, Bryan Van Norden makes the same distinction between the broad sense and the narrow sense of *ren*. The broad sense "seems to refer to the summation of all human virtue," which Van Norden translates as "humaneness." The narrow sense refers to "benevolence" and consists in "loving others." *Virtue Ethics and Consequentialism in Early Chinese Philosophy,* 117-118.

system of Confucianism" because it "gives 'meaning' to all the other ethical norms that perform integrative functions in a Confucian society."[63] In its broad sense as perfect virtue, *ren* is linked with the internal process of the cultivation and moral perfection of the self. [64] Chan believes the key to the understanding of this general virtue is found in Confucius' teaching that *ren* is "to love human beings" (*Analects* XII. 22).[65] On this basis, Chan follows the Han Confucianists in equating *ren* with "love" (*ai* 愛) then goes on to explain *ren* in terms of *love*. When *ren* is applied to concrete situations, the procedures used to discern how one ought to treat others are known as of *zhong* 忠 ("loyalty") and *shu* 恕 ("reciprocity"), the two words that capture the *dao* of the Master (the *Analects* 4.15).[66] The principle of *zhong shu* 忠恕 is used to discern what one ought to do (or not do) to another person, asking what one would like or dislike were one in the other's position.[67]

An important issue related to *ren* as love is whether this love is universal, and whether it is to love all human beings equally. On this point, Chan maintains that Confucianists promote both a universal love *and* the doctrine of love with distinctions *ài*

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[63] Tu Wei-ming, *Humanity and Self-Cultivation: Essays in Confucian Thought* (Berkeley: Asian Humanities Press, 1979), 6-9.
[64] Ibid.
[65]Chan, "The Evolution of the Confucian Concept *Jên*" 299.

[66] E. Bruce Brooks argues that 4.15 is not part of the original *Analects*, but a later insertion by followers of Zeng Shen. See, *The Original Analects: Saying of Confucius and His Successors*, (New York: Columbia University Press, 1999), 249-479. In spite of this dispute, it is clear that *zhong* and *shu* are central to Confucius' teachings.

[67] See D. C. Lau, *The Analects,* 2nd ed, (Hong Kong: The Chinese University Press, 1992/2000), xv-xvi. See also David S. Nivison, "Zhong (Chung) and Shu: Loyalty and Reciprocity" in Cua, *Encyclopedia of Chinese Philosophy*, 882-885; Fung Yu-lan, *A Short History of Chinese Philosophy,* 42-43. Similarly to Fung Yu-lan, Wing-Tsit Chan also understands *zhong* and *shu* in terms of the Golden Rule. Chan, "The Evolution of the Confucian Concept *Jên,*" 299-230.

yǒu chà děng (愛有差等). In Chan's view, the dispute between Mencius and the Mohists was not about universal love in itself, but the distinctions made in the application of love. Like Mohists, Confucianists also promote universal love. In the *Analects*, Confucius taught his disciples to "love all people" (I. 6). Mencius also said, "The man of *ren* loves everyone" (*Mencius* VIIA. 46). But unlike Mohists, Confucianists do not promote equal love for all, for they believe that it is impracticable for people to treat everyone exactly as they would treat those nearest to them. For example, people cannot be expected to provide support for everyone else in the same way they would support their parents. In the Confucianist view, the application of love necessarily involves making distinctions in favor of those closest to oneself. The Confucianist doctrine of "love with distinctions" recognizes Five Relationships: ruler-minister, parent-child, husband-wife, elder sibling-younger sibling, and friend-friend (*Doctrine of the Mean* 20; *Mencius* 3A.4).[68] Of these, three are recognized as the most important, known as the Three Bonds: ruler-minister, father-son, husband-wife. Confucius said that the son is not required to report the father's crime of theft to the authority, for "uprightness" (zhi, 直) is found in honoring the special bonds of relationship (*Analects* 13.18). For Confucianists, it is *natural* to love those nearest to oneself more. Furthermore, the familial bonds of love are also the origin of the universal love. Confucius' disciple Yu Tzu stated, "Filial piety (孝) and brotherly respect (弟) are the root of *ren* (仁)" (*Analects* I.2).[69] The application of love necessarily starts with one's parents, then extends outward to others in society, using the Confucianist procedures of *zhong shu* to decide how to treat others by discerning what

[68] See James T. Bretzke, "The Tao of Confucian Virtue Ethics," 29.

[69] Chan, "The Evolution of the Confucian Concept *Jên,*" 301.

one would like for oneself in a similar situation. But love must first of all be shown to relatives, as this teaching is found in a number of Confucianist texts. In the *Doctrine of the Mean* (20), it is stated that the great exercise of *ren* consists in "showing affection for relatives." In *Mencius*, the essence of *ren* is said to be "in serving one's parents" (IVA.27), and to "show affection toward relatives" (VIB.3; VIIA.15). As Mencius puts it, "Treat with respect the elders in my family, and then, by extension, also the elders in other families. Treat with tenderness the young in my own family, and then, by extension, also the young in other families" (IA.7).[70] The universal love is thus an extension of the familial love. Nevertheless, it is necessary to make distinctions in the application of love in favor of those bound to oneself by a special bond.[71]

Ren in the Confucianist tradition is thus a universal love that includes all persons, but it favors those more closely connected to the agent by the familial bonds. In addition, Confucianists also show a partiality for the virtuous. This is reflected in Mencius' teaching, "The man of *ren* embraces all in his love, but what they consider of the greatest importance is to cultivate an earnest affection for the virtuous" (VIIA. 46).[72] This partiality is reflected in Lãn Ông's directives on the special care for devoted wives and dutiful children in his *Moral Precepts for Physicians*. Mencius also combines *ren* with *yi* 義, where *yi* is translated as *righteousness* and understood in terms of one's disposition

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[70] Ibid, 301-302. These citations from the *Analects*, *Doctrine of the Mean* and *Mencius* are based on Chan's translation, which I think is better than the translation of James Legge or D. C. Lau.

[71] Chan believes the decline in the Mohist doctrine of universal love is because it is "unreasonable, impracticable, and therefore defective." Another reason for its decline may have been that its motive was utilitarian. Chan, "The Evolution of the Confucian Concept *Jên,*" 302. Bryan Van Norden also refers to the Mohist ethics as utilitarianism. See Bryan Van Norden, *Virtue Ethics and Consequentialism in Early Chinese Philosophy*.

[72] Chan, "The Evolution of the Confucian Concept *Jên,*" 301.

and action with regard to the Five Relationships. Vietnamese scholar Nguyễn Đăng Thục explains that for Mencius, *yi* is often understood in the context of the particular love for those closest to oneself, while *ren* denotes the more universal love for all humans. While Mo Tzu insisted on universal love without distinctions, and Yang Zhu insisted on self-love, Mencius stressed *ren* and *yi* so as to balance the requirements of the universal love against the particular love toward one's family clan.[73] This is in line with Chan's view when he wrote, "It is love [*ren*] that embraces all relations, but it is righteousness [*yi*] that distinguishes them" and with Chan's assertion that Confucianism stresses both universality and particularity.[74] Mencius is also famous for his insistence that the good ruler ought to seek *rén* 仁 (humaneness/love) and *yi* 義 (righteousness) rather than profit (lì 利), because he considered profit the diametric opposite of *ren* and *yi* (*Mencius* 1A.1). This disparaging of profit is reflected in Lãn Ông's *Moral Precepts for Physicians*, because he believes physicians ought to act according to *ren* rather than seeking profit so as to be worthy of the healing art.

4.5.2. Humaneness Specifics in Lãn Ông's Medical Ethics

In Lãn Ông's writings, *ren* is referred to frequently as the defining virtue and the basis of medicine. Lãn Ông's understanding of this virtue can also be examined under two headings which reflect the two meanings of *ren*: (1) *ren* as the summation of the virtues; and (2) *ren* as the commitment to the good of others. In its broader sense as perfect

[73] Nguyễn Đăng Thục, *Lịch Sử Tư Tưởng Việt Nam* [A History of Vietnamese Thought], Vol. VI-VII (Hochiminh City, NXB Tp Hochiminh: 1992), 5-12.

[74] Chan, "The Evolution of the Confucian Concept *Jên,*" 302.

virtue, *ren* is linked with the internal process of self-cultivation. This resonates with Lãn Ông's emphasis on the moral cultivation of physicians who are to practice *ren* through the healing art. In its narrow sense, *ren* refers to the personal commitment to the good of others, which Chan translates as *benevolence*. This is reflected in Lãn Ông's directives on the professional duties and the social responsibilities of physicians. Lãn Ông's understanding of *ren* can therefore be discussed in terms of (1) self-cultivation, (2) the professional duties of physicians, and (3) the social responsiblities of physicians. Let us examine these in turn.

First, *ren* as the goal of self-cultivation features significantly in Lãn Ông's texts because *ren* is understood as the basis of the medical art. For Lãn Ông, because medicine is *ren shu* 仁術 or "the art of *ren,*" physicians must become persons of *ren* through the ongoing process of self cultivation. The *Great Learning* teaches that self-cultivation is the root, while training in the art is the branch: the root has to be strong so that the branch can be healthy.[75] In line with this teaching, Lãn Ông believes that the root of medical practice is the virtuous character of the physician. As discussed in Chapter Three, Lãn Ông's view of moral cultivation is connected with his understanding of the *dao* of medicine (*yī dào* 醫道).[76] The term *dao* has two levels of meaning: primarily it refers to the interior process of self-cultivation; secondarily it refers to the way one engages in one of the arts so as to serve the good of others. To embrace the *dao* of medicine is to commit oneself to the primary task of self-cultivation, and to engage in the secondary

[75] See Yanming An, "Daxue (Ta Hsueh): The Great Learning" in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy* (New York/London: Routledge, 2003), 232-233.

[76] Lãn Ông's Preface to his medical compendium *Hải Thượng Y Tông Tâm Lĩnh* , 20.

task of serving others through the healing art. The secondary task (service) is built upon the primary task (self-cultivation) and presupposes it. Conversely, the (secondary) task of service also helps perfect the (primary) task of self-cultivation. In regard to its primary meaning, *dao* is interconnected with *ren*, for it is related to a process of becoming truly a human person.[77] Lãn Ông refers to the *dao* of medicine because it is a way – among others – which enables the practitioner to serve the good of society while aspiring to the highest good.[78] Through the medical art, medical practitioners continue to cultivate themselves in virtue by committing to the moral standards of medicine in the service of the community. Because the basic virtue of medicine is humaneness (*ren*), medical practitioners ought to manifest this virtue through humane acts in the service of patients, and to cultivate themselves continually in humaneness by adhering to the moral directives which he specifies.

In his *Moral Precepts for Physicians*, several of Lãn Ông's directives on self-cultivation refer to *the heart*, the center of one's moral character. Lãn Ông insists that physicians ought to keep their hearts from being tainted with insincerity (Precept 2). In line with Mencius' teachings (*Mencius* 4A.1), Lãn Ông insists that physicians are to keep the purity of heart 存心端正 (*cún xīn duān zhèng*) and to guard themselves against the domination of selfish or lustful desires (Precept 3). This involves a degree of vigilance in regard to one's inner thoughts and inclinations, which is a crucial part of self cultivation

[77] James T. Bretzke, "The Tao of Confucian Virtue Ethics," 35; "Moral Theology out of Asia" in *Theological Studies*, 61(2000), 112-115.

[78] This is the understanding of *dao* in the *Great Learning*.

according to the teaching of the *Doctrine of the Mean* (ch.1).[79] Lãn Ông insists that medicine is a dignified art 清高之術 (*qīng gāo zhī shù*), and physicians ought to cultivate a dignified character 清高之節 (*qīng gāo zhī jié*) so as to be worthy of the art (Precept 9). In his chapter "*Cases that Resulted in Death*," Lãn Ông refers to the generosity of heart 恆心 (*héng xīn*) as the necessary virtue and greed as the vice in medicine.[80] In Lãn Ông's view, the dignified character requires a certain degree of detachment from desires for profit and fame. The professional duties frequently confront physicians with moral choices, and the good physician would choose to serve patients, even when it involves a loss of profit or harms his or her reputation. In this regard, ambition for high office or desire for wealth can distract physicians from performing their proper role. Self-cultivation is therefore directed toward service of others through the medical art.

Second, *ren* as the commitment to the good of others is the basis of the professional duties of physicians in Lãn Ông's medical ethics. *Ren* in this narrow sense is translated as "benevolence" by Wing-Tsit Chan and Bryan Van Norden.[81] Recall that in the Hippocratic tradition, beneficence is the basis of medical practice, because it refers to the way physicians are to use their skills and knowledge in the service of patients. In Drane's virtue theory, the corresponding virtue "benevolence" is the cardinal virtue which reflects this fundamental commitment to the good of patients. This resonates with

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[79] See Kwong-loi Shun, "Cheng (Cheng): Wholeness or Sincerity," in Antonio S. Cua (ed) *Encyclopedia of Chinese Philosophy* (New York/London: Routledge, 2003), 37-38.

[80] Lãn Ông, "Y Âm Án," Case 3, in *Hải Thượng Y Tông Tâm Lĩnh*, 460-461.

[81] Wing-Tsit Chan, "The Evolution of the Confucian Concept *Jên,*" 297. Bryan Van Norden also makes the distinction between the broad sense and the narrow sense of *ren*. The narrow sense refers to "benevolence" and consists in "loving others." The broad sense "seems to refer to the summation of all human virtue," which also includes benevolence. Van Norden translates this as "humaneness." *Virtue Ethics and Consequentialism in Early Chinese Philosophy,* 117-118.

Lãn Ông's view in which *ren* is understood as the basis of professional duties. According to Lãn Ông, highest among the physician's moral duties is professional competence. In Precept 1, Lãn Ông stresses that physicians ought to study diligently and train continuously so as to excel in the medical art. Lãn Ông frequently laments the lack of competence among practitioners of his day, and warns his disciples against the vices of ignorance and laziness. Another major concern in Lãn Ông's texts is the widespread dishonesty and fraud among medical practitioners of his time. Lãn Ông promotes the virtue of *sincerity* (*chéng* 誠, thành) among physicians in the face of such pervasive abuse of the physician's position. Lãn Ông is acutely aware of the state of vulnerability of the patients and their families who have to be dependent upon the physician because of illness. In his view, to take advantage of patient's vulnerability and dependence for personal gain is contrary to the healing art because it violates *ren*, the very basis of medicine. Lãn Ông's insistence on professional competence and sincerity of physicians can be interpreted as an effort to establish and protect the fiduciary nature of the medical profession, by ensuring that physicians are trustworthy in their professional role.[82] In Precept 2, Lãn Ông explains that sincerity is necessary because medicine is based on trust. Physicians must have the people's trust in order to achieve good results.

For Lãn Ông, *ren* in medical ethics shows itself most clearly in the physician's attitude toward human lives. As guardians of human lives, physicians ought to make themselves available to provide medical assistance and to save people's lives (Precept 4).

[82] Cf. Laurence McCullough, John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine (Dordrecht; Boston: Kluwer Academic, 1998). McCullough argues that John Gregory had a key role in making British medicine a fiduciary profession by his emphasis on both professional competence and honesty among physicians. Professional competence and honesty are also the two major concerns in the vast majority of codes of medical ethics around the globe.

The ideal of service promoted in Lãn Ông's texts involves a strong commitment that entails personal costs for the physician. This commitment demands that physicians put human lives above profit, and avoid evading difficult cases. On the contrary, physicians should work hard to save people's lives, and stand by their patients who suffer from critical illness. The respect for human lives also requires physicians to be prepared and have the therapeutic resources available in adequate amounts in order to serve the urgent health needs of patients (Precept 6). The same respect for human lives also demands that physicians be cautious in creating new apothecary formulae, and avoid callously creating new formulae to experiment on persons (Precept 6). On this point, Lãn Ông shows an acute awareness of the power imbalance in the physician-patient relationship, and the state of vulnerability and dependency of patients caused by their illness. To practice *ren* in this context involves restraining oneself from exploiting patient's vulnerability, and providing quality medical care for the patient. In line with this respect for patients, Lãn Ông instructs his disciples to disclose medical information and the proposed treatment plan adequately to patients and/or their family prior to treatment, so as to allow patient involvement in the therapeutic process (Precept 5).

In view of the understanding of *ren* as both *universal* and *graded* love in Confucianist tradition, it is significant to find Lãn Ông's uncompromising belief in the basic equality of human persons. Consistent with the Eastern medical tradition, Lãn Ông insists that patients ought to be treated equally, regardless of their wealth or social status (Precept 2). In agreement with Chen Shih-kung, Lãn Ông requires physicians to treat female entertainers and prostitutes with the same respect as they would treat women of reputable families (Precept 3). This indeed reflects the understanding of *ren* as universal

love for all human persons. Furthermore, while Wing-Tsit Chan explains that *ren* ordinarily should be *love with distinctions* in its application to favor those closest to oneself by special relationships, Lãn Ông demands that physicians treat their patients equally. This highlights the public role of physicians, who ought to have a basic commitment to the good of all in need within the community who seek their assistance.

Third, that *ren* is the basis of the social responsibilities of physicians is also apparent in Lãn Ông's writings. In Lãn Ông's view, physicians carry out their social role first and foremost by performing their professional role well, as prescribed by the theory of Rectification of Names. As practitioners of the art of *ren*, they ought to cultivate the humane heart and conduct themselves in manners worthy of that name, because the order and functioning of society are dependent on it. Furthermore, physicians also serve the good of society by setting good examples for others by their moral integrity and dedicated service to their patients. Most significantly, Lãn Ông believes that physicians have a social responsibility to care for those most in need: the orphans, the widows and the lone elderly in the community. On this point, there is some resonance with the view held by Matthew Wynia and his co-authors that the professions play a crucial role in the protection of vulnerable persons in society.[83] These authors maintain that the professions are custodians of certain social mores and values, such that a decline in professionalism would lead to a rise in societal problems. Lãn Ông maintains that physicians ought to provide, out of their own funds, for patients in dire need, especially the dutiful wives and the filial children who are in poverty. On the contrary, Lãn Ông believes that those who

[83] M. K. Wynia, S. R. Latham, A. C. Kao et al, "Medical Professionalism in Society," in *New England Journal of Medicine* 341 (1999): 1612-16.

become poor and sick as the result of their reckless behavior do not deserve as much sympathy (Precept 8). This reflects the partiality for the virtuous in the Confucianist tradition (*Mencius* VIIA. 46).

4.6. THE CORRELATION BETWEEN LUKE'S MERCIFUL LOVE AND LÃN ÔNG'S HUMANENESS

Having examined Luke's view of Christian love through Jesus' healing acts and the double love command, and Lãn Ông's understanding of *ren* in medical practice, we are now in a position to examine how they correlate to each other. In her recent book, Catherine Cornille maintains that interreligious dialogue is "an essential feature of peaceful coexistence" in today's context, and "a promise for religious growth" for those involved.[84] Cornille identifies a number of necessary conditions for true dialogue across religious traditions: humility, the rootedness in a tradition, interconnection, empathy, and hospitality toward the other. Cornille believes that a basic condition for interreligious dialogue is "a sense of commonality or solidarity among religions," and true dialogue presupposes a shared conviction that despite significant and ineradicable differences, "religions may find one another in a common ground."[85] In line with the current intellectual climate which emphasizes particularity and distinctiveness, Cornille maintains that the search for commonality must not overlook the fact that "each religion derives from a different source, pursues different goals, and develops its own culturally

[84] Catherine Cornille, *The Im-Possibility of Interreligious Dialogue* (New York : Crossroad Pub. Co., 2008), 1.

[85] Ibid, 95.

specific set of values and beliefs."[86] Cornille believes there are external challenges that call for interreligious dialogue: increasing secularization, the mandate of world peace, and the alleviation of suffering. Another significant issue related to dialogue across traditions is the phenomenon of multiple religious affiliations in today's cosmopolitan context. In an earlier book, Cornille sees the increasing numbers of persons with multiple religious belonging in the West as a reflection of the form of religiosity that has been prevalent elsewhere in the world, especially in the East.[87] In China and Japan, as well as India and Nepal, to claim affiliation to more than one religious tradition is often considered the norm rather than the exception. Cornille outlines the three approaches to multiple religious belonging that are discussed in the book: (1) to focus on the ultimate religious experience at the base of all traditions, (2) to remain faithful to the core doctrines of one tradition while interpreting them through the hermeneutical framework of another, and (3) to acknowledge the complementarity of religions.[88] In the religious history of Vietnam, the tendency to draw freely from diverse religious traditions and to harmonize differences is based on the belief that "Three religious traditions share the same root." In regard to the complementarity of religions, Cornille writes,

> While Christianity is based on the belief in Jesus Christ as the full and final revelation of God, there are various ways in which the existence of other religions may be recognized, not merely over against, but alongside Christianity. This requires a strong awareness of the eschatological nature of Christian faith, as well as the belief that other religions play a distinct and revelatory role in God's plan of salvation. While Christians may or must believe they have a privileged understanding of the will of God in Jesus Christ, other religions may exercise a

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[86] Ibid, 96.

[87] Catherine Cornille (ed), *Many Mansions? – Multiple Religious Belonging and Christian Identity*, (Maryknoll, New York: Orbis, 2002), 1.

[88] Ibid, 5-6.

> critical and constructive function in the process of discovery of the fullness of truth and the pleroma of Christ at the end of time.[89]

There are considerable overlaps between the issues concerning interreligious dialogue and those related to multiple religious belonging, because in each case the central question is how to understand a given religion from the standpoint of another. For Christians of the West, to engage in dialogue with Confucianists is to locate points of connection between two traditions so as to foster mutual understanding and peaceful coexistence amidst diversity. For Vietnamese Christians, Confucianism is part of the received cultural heritage that must be reconciled with Christian beliefs and practices. The work of the Jesuit missionaries in China and Vietnam in the sixteenth and seventeenth centuries provides us with interesting examples of inculturation in the Confucianist social context, and illustrates some of Cornille's points on dialogue across traditions.

The Jesuit missionary Matteo Ricci (1552-1610), in his influential work *T'ien-chu shih-i* [*The True Meaning of the Lord of Heaven*], gives a remarkable example of inculturation by using terms and concepts embedded in Confucianism to convey Christian doctrines to the Chinese literati.[90] Against the trend of Neo-Confucianism of the Sung-Ming era to explain the origin of the universe in terms of *li* (理, principle) and *ch'i* (氣, air, energy), Ricci called for the revival of the concept of *Shang-ti* (Lord-on-

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[89] Ibid, 6.

[90] For English translation, see Matteo Ricci, Guozhen Hu; Edward Malatesta, *The True Meaning of the Lord of Heaven*,= *T'ien-chu shih-i*, translated, with introduction and notes, by Douglas Lancashire and Peter Hu Kuo-chen; edited by Edward J. Malatesta, (St. Louis : Institute of Jesuit Sources, 1985). Ricci's work had significant influence on a later Jesuit missionary to Vietnam, Alexander de Rhodes, as shown in the *Cathechismus* which de Rhodes composed for his missionary work in Vietnam.

High) Who was worshipped by the Chou emperors.[91] Ricci believed that the deity known as *Shang-ti* or *T'ien* is identical with *Deus* or the Christian God, Who had not only created all things, but continued to govern and sustain them. Most significant for our current discussion is Ricci's explanation of the Christian love in terms of *ren*,

> The meaning of *jen* can perhaps be exhausted by two expressions: to love God [and] to regard him as superior to all. To practice these two [attitudes], one would be able to possess all virtues. These two expressions however, are actually one. If one loves a person, one also loves what this man cherishes. God loves mankind [equally], and if one really loves God, is it possible, then, not to love mankind?[92]

It is evident that although Ricci used the language of *ren* to address the Chinese literati, his interpretation of *ren* was heavily influenced by the double love command of Christianity, which Ricci believed would perfect the Confucianist understanding of *ren*. Ricci was convinced that though Confucius' teachings were sound, the Chinese Master was only a preparation for Christianity, which alone can fulfill all the needs and yearnings of humanity.[93] Ricci maintained that, because all persons under heaven were created by God, the person of *ren* would love and care for all, while the small-hearted man (*xiao ren,* 小人) would love only his own kindred.[94] Ricci's contribution to the integration of the idea of God into the Confucianist moral structure was his assertion that every person has three fathers: God, one's monarch, and one's own father. The idea of God as the Common Father (*Gong Fu,* 公 父) of all is the basis of the fraternity among

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[91] John D. Young, *Confucianism and Christianity: The First Encounter* (Hong Kong: Hong Kong University Press, 1983), 29.

[92] Matteo Ricci, *T'ien-chu shih-i*, hsia-chuan, p. 46. Quoted in Young, *Confucianism and Christianity: The First Encounter*, 37.

[93] John D. Young, *Confucianism and Christianity: The First Encounter*, 36.

[94] In Confucianist ethics, the "small-hearted man" (*xiao ren*) is the diametric opposite of the "paradigmatic person" (*junzi*).

all persons. Ricci writes,

> The monarch's relationship to oneself is that of lord and subject. The relationship of the family master (chia-chun) to oneself is that of father and son. But, when compared to the relationship of God as the common father, all earthlings' relationships of lord and subject, father and son, are equal to the relationship of brothers [among brothers].[95]

Against the backdrop of the Confucianist esteem of the social hierarchy, Ricci's view reflects the Christian belief in the basic equality of all in the eyes of God. This egalitarianism is also reflected in his work *Chiao-yu lun* [*On Friendship*] in which he writes, "The other person is none other than one's other half, one's second self."[96] Ricci's *T'ien-chu shih-i* had significant influence on a later Jesuit missionary to Vietnam, Alexander de Rhodes (1591-1660), as shown in de Rhodes' most important work, the *Cathechismus*.[97] While there are substantial differences between de Rhodes' Catechesis and Ricci's work, the apostle of Vietnam shared many of Ricci's ideas, including the identification of the Confucianist Lord-on-High (*Shang-ti* in Chinese and *Đức Chúa Trời* in Vietnamese) with the Christian God, and the three levels of fatherhood (God, the sovereign, father) to whom one ought to pay due honor and veneration.[98]

If the works of Ricci and de Rhodes reflect their concern with inculturation, understood as the exposition of Christian doctrines using Confucianist terms and ideas, the works also reveal their conviction about the common grounds between the two

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[95] Matteo Ricci, *T'ien-chu shih-i*, hsia-chuan, p. 65a-b, quoted in Young, 37.

[96] Matteo Ricci, *Chiao-yu lun,* quoted in Young, 36.

[97] Peter C. Phan, *Mission and Catechesis: Alexandre de Rhodes and Inculturation in Seventeenth-Century Vietnam* (Maryknoll, New York: Orbis Book, 1998), 118-121.

[98] For a discussion on the similarities and differences between Ricci's *T'ien-chu shih-i* and de Rhodes' *Cathechismus,* see ibid, 119-121.

traditions that would allow fruitful dialogue.[99] In this section, the correlation between Christian love in Luke and *ren* in Lãn Ông is grounded in the same conviction about the possibility of dialogue across the two traditions. However, unlike the works of inculturation as pioneered by Ricci and de Rhodes, this present work reflects the perspective of a Christian with a Confucianist cultural heritage, who is both committed to the Christian faith and asserts affiliation with the Confucianist tradition. While the works of inculturation by Ricci and de Rhodes tend to interpret the common areas between the two traditions as proof that Confucianism is *preparatio* for Christianity,[100] this correlation has a more modest aim in mind: to examine the context-rich terms and ideas of the two traditions that share some commonality with each other, in order to bring out insights relevant for Christian medical ethics in today's Vietnamese cultural context. Though this lens is not identical with that of interreligious dialogue, I believe it can provide a good context for fruitful exchange across traditions.[101]

4.6.1. Points of Correlation Between Luke and Lãn Ông

Among the existing challenges that call for interreligious dialogue, Cornille names the alleviation of human suffering as an invitation to action for all persons of faith in the service of human needs. On this point, Lãn Ông's positive view of human action resonates strongly with Luke's understanding of love-in-action as the meaning of Jesus'

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[99] Note that both Ricci and de Rhodes showed little respect for both Buddhism and Daosim. Phan, *Mission and Catechesis*, 120.

[100] See Cornille, *The Im-Possibility of Interreligious Dialogue,* 192.

[101] In the context of interreligious dialogue, Cornille makes a helpful distinction between "hospitality toward similarity" and "hospitality toward difference," the former referring to the tendency to collapse one tradition into the other which occurs most frequently in proselytization, and the latter to true dialogue. Catherine Cornille, *The Im-Possibility of Interreligious Dialogue*, 177-210.

double command (Luke 10:25-37). Lãn Ông not only rejected the fatalistic views that led to apathy and inactivity in health care, he also denounced the tendency among physicians to deny responsibility for their failures on the grounds of fate. He writes, "People usually make a diagnosis based on superficial observations… then follow mechanically the old remedial formulae without adequate understanding or care…when the patient's condition worsens, they blame it on fate."[102] Lãn Ông's medical ethic strongly advocates action to alleviate human suffering, and stresses physicians' accountability for the consequences of their action or inaction. His work ethic demands physicians to work diligently to improve the patient's condition, and to fight for a patient's life when necessary. In his own words, "When the patient is gravely ill, the physician must work hard to find a cure, searching far and wide for the right remedy, finding life among the signs of death, trying one's best to save the patient."[103] Physicians must not refuse people's request for help in an emergency, even when it involves the inconvenience of long distance, of bad weather, or of night call.[104] Lãn Ông's view is well in line with the demands of Luke's Jesus that Christian disciples give themselves in service to those in need, as reflected in the parable of the Good Samaritan (Luke 10:30-37), and in Jesus' own example of service (Luke 22:25-27). At the fundamental level, Lãn Ông's work ethic is grounded in *ren*, understood as love for others, whereas the Lukan Jesus' teaching on service flows out of the double love command, and of God's salvific purpose for humanity. Both Lãn Ông's

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[102] Lãn Ông, Preface to "Y Nghiệp Thần Chương" [The Essentials of Medicine] in *Hải Thượng Y Tông Tâm Lĩnh*, Vol. 1, 27. Again, "fate" is used to render (命), following Tao Lee's translation of Chen Shih Kung's text. It is apparent that neither Lãn Ông nor Chen Shih-kung understood "fate" in the deterministic sense or as "fatalism," for both strongly advocated human action instead of passive resignation.

[103] Ibid.

[104] Lãn Ông, Preface to "Y Dương Án" [Cases Treated Successfully] in *Hải Thượng Y Tông Tâm Lĩnh*, 414.

medical ethics and Luke's theological perspective call for active engagement in the alleviation of human suffering, rather than a passive resignation to the existing circumstances.

Perhaps the most significant point of correlation between Lãn Ông's ethics and the teachings of Luke's Jesus is the centrality of love in the moral life. As previously discussed, *ren* in the Confucianist tradition is understood as both universal love and love with distinctions. The Confucianist tradition demands love for all persons, but greater affection and commitment to one's parents, spouse, children, siblings, and friends. In his writings on medical ethics, Lãn Ông emphasizes the universal and egalitarian aspects of *ren* as he insists on the equal treatment for the poor and the rich, the lower class and the higher class, the female entertainers or prostitutes and women of reputable families. This resonates with the non-discriminatory love which Luke's Jesus embodies in the healing narratives (Luke 22:47-53), and which he enjoins on his disciples (Luke 6:27, 35-36; 10:30-37).[105] Moreover, Lãn Ông's belief that physicians have a social responsibility to care for the most vulnerable in society: the orphans, the widows, and the lone elderly resonates with Jesus' outreach to the widow of Nain (Luke 6:11-16), and Jesus' defense of widows against the tyranny of the scribes (Luke 20:47). While Lãn Ông maintains that physicians ought to provide out of their own funds for patients in dire need, especially the dutiful wives and the filial children who are sick and in poverty, Jesus illustrates his love

[105] As biblical scholars point out, Jesus' demand to "hate father and mother, wife and children, brothers and sister" (Luke 14:26) does not refer to either the nature or extent of the love command in Luke 10:25-37, but to the personal costs involved in the choice for God's reign. Brendan Byrne clarifies that the language of "love/hate" reflects a Semitic sense of preference: the Christian disciple ought to prefer Jesus to members of his or her own family. See Brendan Byrne, *The Hospitality of God,*124-125; Luke Timothy Johnson, *The Gospel of Luke,* 228-233.

command with the story of a Samaritan who puts his possessions in the service of the afflicted man, and gives from his own resources for his continued care. In Luke, Jesus' frequent interventions on behalf of the poor and the marginalized, at times by defending them against those in positions of power, would lend support to Lãn Ông's insistence on inclusiveness and equal treatment of the poor and the outcast. Furthermore, Jesus' hospitality to the "public sinners" of society (Luke 7:36-50; 15:2; 19:1-10) both affirms Lãn Ông's assertion on non-discrimination against female entertainers and prostitutes, and challenges Lãn Ông's lack of tolerance toward those who become poor and sick as a consequence of their "reckless exploits" (Precept 8). In Lãn Ông's defense, there might be an awareness of the different degrees of patient's culpability behind his ethical view, for the women who become entertainers or prostitutes are more often victims of circumstances rather than by choice, whereas those who Lãn Ông thinks deserve less empathy are mostly men who put themselves into desperate situations by their own choice. Nevertheless, it is clear that Jesus demands a more inclusive love and a less discriminatory attitude toward the social outcast than Lãn Ông. As discussed in Chapter Three, Lãn Ông's discrimination against the "culpable" can pose a significant setback for certain areas of medical work, especially in the fight against the AIDS pandemic, where social stigma and prejudice have not only caused tremendous suffering for patients and their relatives, but also made diagnosis, contact tracing, and treatment exceedingly difficult for those in health care. Another point of discrepancy is that Lãn Ông's view of *ren* as inclusive love would extend to all within the ethnographic boundaries of the Vietnamese society, while Jesus' outreach to the non-Jews (8:26-39; 17:12-19), and the evolving understanding of Christian love in Luke-Acts indicates a truly universal love

that includes all ethnicities and cultures within God's plan of salvation. Jesus' acts of mercy extend beyond the bounds of ordinary convention and challenge us to re-examine our own criteria for inclusion and exclusion.

A significant part of Lãn Ông's view of *ren* is his insistence that human lives ought to be valued above profits. In order to uphold the high moral standards of their profession, Lãn Ông believes physicians must cultivate a virtuous character, so as to overcome self-interests and lustful desires that might be associated with their professional role. This resonates with Luke's emphasis on personal conversion as the necessary response to the gospel, and Jesus' numerous teachings on the use of material possessions in the service of those in need (Luke 3:11; 14:13; 12:42; 16:19-26). In agreement with Lãn Ông's esteem of human lives, Luke's Jesus teaches that to value material possessions above human life is contrary to Christian love.

Finally, it can be argued that Lãn Ông does advocate the virtue of religion in medicine as shown by his several references to reward and punishment for physician conduct.[106] In the narrative section (IIa) of his *Moral Precepts for Physicians*, Lãn Ông calls on physicians to adhere to high moral standards in the service of human lives so as to leave *a good legacy for posterity* (*yin-e* 陰隲). The ideograms *yin-e* 陰隲 (synonym *yin-de* 陰德) denote a good non-material heritage that one accumulates by one's generous acts and passes on to one's descendants who may reap great benefit from it. On the contrary, those physicians who deceive and exploit patients' vulnerability for personal gain will not only be scolded by the living but also be condemned by the dead. This

[106] In his book *Becoming a Good Doctor*, James Drane understands the virtue of religion in terms of religious belief, or more broadly, as the recognition of the transcendent dimension in health care, or the attitude concerning the ultimate questions of life. Drane, *Becoming a Good Doctor*, 127-129.

certainly echoes the work of an earlier Confucianist physician Chang Kao, the author of the medical compendium *I-shuo* [*On the Medical Art*] who warned physicians about the retribution for immoral conduct in his chapter *I-kung pao-ying* [*Retributions for medical practice*].[107] The general understanding shared by both authors is that there are inescapable consequences of one's conduct, as either reward for kind and generous acts, or punishments for immoral acts. Though the evil deeds one committed against others may be unknown to most persons in this life, one cannot escape the retributions for such acts. In addition, because physicians are entrusted with the care for human lives, all the more they should guard themselves against immoral acts, as retributions will be far more severe. By the same token, physicians ought not to pass the opportunities to assist persons in dire need, for apathy in the face of great human suffering is also considered a moral failure. Lãn Ông writes,

> When seeing the orphan or widow, the dutiful wife or the filial child who is sick because of poverty, the physician turns away without providing assistance thinking his kindness will be wasted on such persons, it is called "impiety." [108]

The ideograms used for this vice *shī dé* 失德 (literally: "lack of dé 德" here rendered "impiety") denote the moral failure in not responding to the suffering of vulnerable persons when one has the opportunity and the means to do so. In light of what Lãn Ông has written on *yin-e* 陰隲 (or *yin-de* 陰德), *dé* 德 in this case denotes the merit one

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[107] Paul Unschuld, *Medical Ethics in Ancient China: A Study in Historical Anthropology*, (Berkeley/ Los Angeles/ London: University of California Press, 1979), 42-46.

[108] Lãn Ông, "Y Âm Án," in *Hải Thượng Y Tông Tâm Lĩnh*, 461. In general usage, *shī dé* 失德 often indicates the violation of the duty of *lĩ* 禮 ("propriety"), or an offense against one's parent or older sibling, i.e. the offense against the second or fourth relationships (2nd: father-son; 4th: older older-younger brother). In Lãn Ông's usage, the meaning of *shī dé* is more connected with the concept of *cheng-fu* which is explained in the next page.

accumulates as a result of one's gracious acts for others, and "lack of *dé*" means to act without mindfulness of the long term consequences of one's actions. In Lãn Ông's view, to act in accordance with piety *dé* 德 means to conduct oneself with the proper respect for the transcendental dimension of life. It is the awareness – rather similar to the concept of *eusebeia* in the Greek classics – that humans are accountable to beings (or a Being) greater than themselves, and the belief that good conduct is rewarded, while bad conduct is punished by the higher authority.

In regard to the origin of Lãn Ông's (and Chang Kao's) view of retribution, it is important to note that it is rather distinct from the Buddhist concept of karma. In *T'ai-p'ing-ching* 太平經 [*Sutra on the Great Peace*], a second century CE Daoist work from the east China region, there are references to the concept of retribution that reflects Lãn Ông's view.[109] Although *T'ai-p'ing-ching* criticizes Buddhism from a Daoist perspective, it also exhibits some influence from Buddhist doctrines. The work does not mention karma or rebirth, but it does explain the concept of *chéng-fù* 承負[transmission of burden] that seems to be behind Chang Kao's and Lãn Ông's view. According to the doctrine of *cheng-fu*, the good or evil deeds performed by the ancestors have consequences in the destiny of the descendants. The wicked deeds of the ancestors will bring misfortune to the descendants. The burdens brought by the evil deeds of kings would last far longer than those brought by ministers; the burdens caused by ministers would last far longer than those brought by ordinary people. On this point, Kenneth Ch'en stresses that this doctrine is distinct from the Buddhist karma, because the

[109] Kenneth K. S. Ch'en, *Buddhism in China: A Historical Survey,* (Princeton NJ: Princeton University Press, 1964), 48-52.

Buddhist doctrine teaches that the consequences of one's deeds are experienced by one's later reincarnations, not by one's descendants. It is not clear, however, whether or not the doctrine of *cheng-fu* itself is influenced by the Buddhist doctrine of karma.[110]

It is remarkable that the concept of retribution was retained in the writings of Confucianist physicians such as Chang Kao and Lãn Ông, considering the Confucianist aversion to any reference to God or the spirits.[111] In *Analects* 7.20, Confucius was said to avoid discussion on four subjects: "extraordinary things, feats of strength, disorder, and spiritual beings." Though Lãn Ông makes no reference to the spirits in his works, he strongly asserts the certainty of reward and punishment for human acts as the grounds of morality. For Lãn Ông, to act in mindfulness of such consequences is to act in accordance with piety (*dé* 德), while acting with reckless disregard for such consequences is impiety or "lack of *dé.*" This resonates with the teachings of Luke's Jesus who shows the path to eternal life through service to the afflicted (Luke 10:25-37), and warns that the path of apathy and greed will lead to Hades (Luke 16:19-26). It also relates to Jesus' teaching on the last judgment (Luke 12:41-46) when those in positions of leadership and

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[110] Note that Hsi Ch'ao (336-377), a Buddhist author with a Daoist background, explains in his important work *Feng-fa yao* that the effects of karma are borne by the individual alone, rather than by one's descendants. Ibid, 70.

[111] Julia Ching outlines the four classes of gods and spiritual beings in Chinese antiquity: (1) the supreme being or God was called Lord (Ti), Lord-on-high (Shang-ti) during the Shang dynasty, or T'ien (Heaven) during the Chou dynasty, (2) the nature deities, including the deities of sun, moon, wind, clouds, earth, rivers, mountains, (3) the high ancestors, and (4) the other ancestral spirits. Against this background, Confucianism emerged as an ethical humanism oriented to the political order and advocating universal love as the ultimate goal. Ching explains the drift away from the religion of antiquity by pointing to the centuries of unrest toward the end of the Chou era, and the decision of the great Chinese philosophers, beginning with Confucius, to turn toward the human, "While these thinkers had different ideas on many points regarding religion and morality, their common impact was to strengthen the sense of human autonomy and rationality, associating human destiny, fortunes and misfortunes with the activities of human beings themselves rather than with the authority of the ghosts and spirits. Consequently, the system of religious orthodoxy, in belief as well as in ritual order, would not be discarded, although its importance was relativized." Julia Ching in Hans Kung & Julia Ching, *Christianity and Chinese Religions*, (New York/ London/Toronto /Sydney/ Auckland: Doubleday: 1989), 16-17, 63-65.

responsibility are held accountable for the way they have used, or abused, their power. Those who exercise their power for the benefit of ones under their care will be rewarded, while those who abuse their power and mistreat others will be punished.[112] In his parable of the rich man and Lazarus (Luke 16:19-26), Jesus addresses the moral failure of the man who has the opportunity and means but refuses to help another in desperate need. It is the same concern about the apathy among physicians in the face of human suffering that is expressed in Lãn Ông's writings.

4.6.2. Lãn Ông and Contemporary North American Biomedical Ethics

In the last two decades, the interaction between the four principles approach of Western bioethics and the East Asian Confucian societies has highlighted the differences in attitude, value, and emphasis between a Confucian culture and Euro-American liberalism.[113] In particular, the principle of respect for autonomy, which is highly valued in North American culture, does not resonate readily with a Confucian family-based health situation. Ruiping Fan even warns that the uncritical implementation of the four-principles approach, with its individualistic biases, in East Asian Confucian context will

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[112] Byrne, *The Hospitality of God,* 117. Johnson, *The Gospel of Luke,* 203-206.

[113] Fan, Ruiping. 'Self-Determination vs. Family-Determination: Two Incommensurable Principles of Autonomy' in *Bioethics* 1997, Vol. 11, No.3-4, pp. 309–322.

Fan, Ruiping & Benfu Li, 'Truth Telling in Medicine: The Confucian View' in *Journal of Medicine and Philosophy* (2004) 29 (2): 179-193.

Fan, Ruiping and Julia Tao, 'Consent to Medical Treatment: The Complex Interplay of Patients, Families, and Physicians' in *Journal of Medicine and Philosophy* 2004, Vol. 29, No. 2, pp. 139–148.

Angeles Tan Alora and Josephine Lumitao (2001) bring a very useful cross-cultural perspective that highlights the virtues in Filipino health ethics. See Angeles Tan Alora & Josephine M. Lumitao (eds), *Beyond a Western Bioethics: Voices from the Developing World,* (Washington D.C.: Georgetown University Press, 2001).

lead to the fragmentation of families into isolated individuals,[114] and the alienation of people from their own cultural heritage even in their home country.[115] I believe the cultural differences are not to be resolved, but appreciated, so that the local customs and values can be preserved in the globalized world. This means much caution and flexibility is needed in proposing the Western bioethical principles in a Confucian cultural context. On the other hand, the correlation between the four principles and the Confucian structures of decision making can also help to highlight the cultural biases that tend to subordinate the individual person to the good of the group.

Conversely, the study of Lãn Ông's medical ethics also helps bring to light the excesses and biases of the four principles approach in Western bioethics, particularly in favor of the poor and the marginalized. In the Euro-American context of the last three decades, the success of the four principles approach has coincided with the rise of the clinic-centered model of health care in which physician conduct is largely determined by the claims of patient autonomy and patient rights. As the "physician-patient relationship" becomes the normative context for bioethical discourse, concerns for those who are excluded from health services due to lack of insurance get dropped out of the conversation, and of the moral awareness of physicians. For this reason, Lãn Ông's emphasis on both the professional duties and the social responsibilities of physicians, especially in the care for the poor and disadvantaged can help address the imbalance in

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[114] Fan, Ruiping. 'Reconstructionist Confucianism and Health Care: An Asian Moral Account of Health Care Resource Allocation' in *Journal of Medicine and Philosophy*. 2002, Vol. 27, No. 6, pp. 675–682 .

[115] An example in Vietnamese context: in 2008, author Huỳnh Tấn Tài, of the University of Illinois Chicago, was part of the Joint Commission that proposed a working bioethical framework for Vietnam. This proposal draws exclusively on North American authors, and details practical ways to balance the principles of beneficence and non-maleficence against respect for autonomy. Article in Vietnamese, with bibliography, accessed on April 19, 2011 at: http://www.ykhoanet.com/binhluan/huynhtantai/080103_huynhtantai_YducVN.pdf.

Euro-American bioethics. As this chapter has shown, in Lãn Ông's medical ethics, *ren* is understood as both the goal of self-cultivation and the commitment to the good of patients through medical service. Because medicine is the art of humaneness (*ren,* 仁), medical practitioners should perform their professional role diligently and fulfill their social responsibilities in the care for the most vulnerable in society so as to be worthy of that name. In Lãn Ông's view, care for the orphans and the widows, the dutiful wives and filial children who are sick because of poverty, is not optional, and an integral part of the physician's role. The physician who turns away without providing assistance in such situations is impious and blameworthy.[116]

In addition, Lãn Ông's medical ethics also emphasizes self-cultivation, and the place of virtue and character in health care. As guardians of human lives, and ones who exercise power in matters of life and death, physicians ought to keep the purity of heart, and to guard themselves against selfish and lustful desires. In Lãn Ông's view, the dignity of the medical art requires a certain degree of detachment from desires for profit and fame, and the good physician ought to value human lives above profit. For Lãn Ông, self-cultivation is directed toward the service of others through the medical art, including the service of the poor and disadvantaged in community.

In light of the principle of respect for autonomy in North American bioethics, which demands adequate disclosure of information to patient and informed consent prior to treatment, it is interesting to find Lãn Ông's instruction to his disciples in the late

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[116] Lãn Ông, "Y Âm Án," in *Hải Thượng Y Tông Tâm Lĩnh*, 461. In general usage, *shī dé* 失德 often indicates the violation of the duty of *lĩ* 禮 ("propriety"), or an offense against one's parent or older sibling, i.e. the offense against the second or fourth relationships (2nd: father-son; 4th: older older-younger brother). In Lãn Ông's usage, the meaning of *shī dé* is more connected with the concept of *cheng-fu* which is explained in the next page.

eighteenth century,

> *When the patient suffers from a grave illness, and you want to do all you can to restore the patient to health, though it is a beautiful desire, you must explicitly explain [the treatment] to the patient's family before giving the prescription; they will do what they can to get the medicine. If the medicine brings good results, you have their admiration. Even if the illness turns worse, there will be no complaints, and you will have a clear conscience.* (*Precept 5*)

This Precept is Lãn Ông's innovative contribution, which is distinctive from the instructions of other Confucianist physicians prior to him. Note that his instructions on the disclosure of medical information, which remarkably resonates with the modern concern with informed consent, shows a high regard for the patient's family which is the ordinary structure of decision making in a Confucian context. Disclosure of medical information would allow the participation of the patient and the patient's family to occur in regard to the treatment plan. Lãn Ông has in mind the kind of explanation that would lead to patient agreement and cooperation, such that no complaints will follow, even if the outcome is undesirable. This disclosure of information aims toward reaching an agreement between the physician and the patient and/or the family prior to giving treatment. Lãn Ông's directive does suggest that respect for patient's wishes does not have to involve the fragmentation of family structures into isolated individuals. It also shows that dialogue with the past, and across cultures, can help throw light upon our present dilemmas.

4.7. CONCLUSION

If Luke's healing narratives are congruent with the teleological structure of virtue ethics, and the *imitation of Christ* motif, Jesus' double love command in Luke illustrated by the

Good Samaritan story further highlights the exemplary nature of Jesus' healing acts. It also emphasizes the non-discriminatory love which Jesus embodies in his healing acts, and links Christian love with concrete acts of mercy and hospitality in the service of the afflicted. The inclusive love that Jesus illustrates with this parable also reflects the evolving theme of universality in Luke-Acts. Jesus' double love command which involves special care for afflicted persons without discrimination reflects the universality of God's salvific purpose for humanity as presented in Luke-Acts. Luke's theological perspective has significant implications for Christian health care because it presents the Church's mission as a continuation of Jesus' earthly ministry. In this light, Christian health care ought to be in conformity with Jesus' outreach to the afflicted, the handicapped and the marginalized in the service of God's salvific purpose for humankind.

There are strong similarities between the Lukan view of Christian love and Lãn Ông's understanding of *ren*, the defining value of his medical ethics. While *ren* in Confucianism denotes a universal and graded love in favor of those closest to oneself, Lãn Ông accents the universal and egalitarian aspects of *ren* in health care. This resonates with the non-discriminatory love which Luke's Jesus embodies in the healing narratives, and which Jesus teaches through the parable of the Good Samaritan. Furthermore, *ren* in Lãn Ông's medical ethics is the basis of both the professional duties and the social responsibilities of physicians. Among the social responsibilities of physicians is the care for the poor orphans, widows, and lone elderly in the community. This echoes Jesus' ministry to the poor and the social outcast in Luke. Lãn Ông's

insistence that human lives ought to be valued above profits resonates with Luke's emphasis on personal conversion and the right attitude towards material possessions. Lãn Ông's references to reward and punishment for physician conduct also correlate with Jesus' teachings on mercy and apathy, and their consequences (Luke 10:25-37, 16:19-26). As this chapter demonstrates, the virtue-based approach to health ethics allows the context-rich values and concepts in each tradition to surface. It also promotes correlation of ideas and beliefs across cultures while preserving the distinctiveness of each. Nevertheless, once similar ideas are laid out side by side, mutual enrichment begins to occur.

Chapter V: CATHOLIC AIDS CARE NETWORK IN VIETNAM: CHRISTIAN LOVE AND HUMANENESS IN ACTION

5.1. INTRODUCTION

In this final chapter, I discuss the way the healing communities that make up Vietnam's Catholic AIDS care network give witness to the Christian love which is shaped by Luke's healing narratives, and how their commitment to the care of neglected patients also illustrates Lãn Ông's virtue of humaneness. The Chapter highlights the connections between personal virtues, the community that bears witness to Christ the healer, and social action on behalf of the most disadvantaged in society. Many stories related in this paper are connected with my recent fieldwork in Ho Chi Minh City, where Catholic women and men, lay, religious, and clergy are taking a vital leadership role in the fight against the AIDS epidemic.[1] As Dr. Peter Piot, the former executive director of UNAIDS rightly points out, HIV/AIDS is an exceptional disease that demands a concerted, global response because it both exaggerates existing social inequalities and creates devastating impacts upon a nation, by depleting its economic resources and wiping out its labor force.[2] Along similar lines, Lisa Cahill asserts that AIDS is primarily a justice issue, because it is related to the social structures and relationships that render certain groups of persons particularly vulnerable to infection.[3] For this reason, AIDS care and HIV

[1] I am most grateful to Ms Nguyễn Thị Vinh, Fr. John Phương Đình Toại, M.I., Fr. Nguyễn Viết Chung, Dr. Nguyễn Đăng Phấn who shared their experiences with me in AIDS care during my visits in 2008 and 2011.

[2] Peter Piot, 'Why HIV/AIDS Is Exceptional,' address at London School of Economic, February 8, 2005.

[3] Lisa Sowle Cahill, "AIDS, Justice, and the Common Good" in Keenan (ed), *Catholic Ethicists on*

prevention are best construed within the framework of action for social justice, because health care initiatives must also address the underlying social issues that predispose persons, especially women and children, to the deadly virus. Jonathan M. Mann argued that AIDS is a human rights issue, and pointed to the "societal determinants of vulnerability" to HIV as the proper focus of health intervention.[4] Among such societal determinants are poverty, lack of education, gender inequality, racism, discrimination and marginalization of HIV-infected persons. These societal factors can effectively reduce people's capacity to make informed decisions about their health. The Catholic network of AIDS care in Vietnam, which consists of a specialized hospital for AIDS patients, specialized outpatient clinics, detoxification and counseling centers, shelter for unsupported AIDS patients, and shelter for orphans and mothers affected by HIV/AIDS, serves as a concrete example of Christian love in action, and also mirrors crucial aspects of Lãn Ông's medical ethics. This service network embodies the Christian vision of health care discussed in the my previous Chapter through the formation of the *healing communities* that include nurses and physicians, community health workers, counselors, and chaplains who share a common commitment to persons affected by HIV/AIDS when society deserted them. Their works with HIV infected persons provide a powerful illustration of the social dimension of health care, the role of the healing community, and the *social significance* of the virtues of mercy, hospitality, and solidarity embodied by Luke's Jesus. This Chapter outlines a range of *social action* these Catholic communities undertake through health services, education, accompaniment, advocacy, and the

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HIV/AIDS Prevention, 282-285.

[4] Jonathan M. Mann, 'Human Rights and AIDS: The Future of the Pandemic' in Jonathan M. Mann (ed), *Health and Human Rights* (New York: Routledge, 1999), 216- 225.

provision of shelter and support for vulnerable persons with HIV/AIDS. Their works also reflect Lãn Ông's concern for the poor widows and orphans affected by illness, and his stress on the physician's duty to put human lives above profit. My present study looks at AIDS care from a virtue ethics perspective, and demonstrates that the teachings and healings of Luke's Jesus not only can inspire and sustain the Christian commitment to the care and defense of infected individuals and their families, but can also challenge the societal factors that predispose persons to greater HIV risks, and foster a solidarity for social change.

5.2. THE CATHOLIC AIDS CARE NETWORK IN VIETNAM

5.2.1. Background – HIV/ AIDS in Vietnam

The first case of HIV infection in Vietnam was reported in December 1990 in Ho Chi Minh City. In the following few years, as testing became more accessible and reporting was more systematic, there were signs that HIV/AIDS was in fact a significant problem in Vietnam. The response of the Vietnamese Government has been slow and reactive, because it does not consider HIV/AIDS a major public health issue.[5] In December 2005, the cumulative number of infected people reported from the 64 provinces totaled 104,111. Of these, 13,731 were new infections, and 10,071 had died.[6] In 2009, UNAIDS

[5] According to the PEPFAR Vietnam Operational Plan Report FY 2011, "HIV/AIDS is not the leading public health concern for Vietnam, however through PEPFAR our programs have attempted to highlight the serious consequences of ignoring this burgeoning epidemic. PEPFAR activities – from providing lifesaving medicines in local clinics to helping shape national policy and legislation – have played an important role in promoting trust and cooperation between the United States and Vietnam during its relatively young diplomatic relationship of just 15 years."

[6] Thu Anh Nguyen, Pauline Oosterhoff, Anita Hardon, Hien Nguyen Tran, Roel A Coutinho, and Pamela Wright, "A Hidden HIV Epidemic Among Women in Vietnam" *BMC Public Health*, 2008. At http://www.biomedcentral.com/content/pdf/1471-2458-8-37.pdf. Accessed November 27, 2012.

estimated 280,000 people in Vietnam were living with HIV, among them 81,000 were women, and 14,000 died because of AIDS.[7] As the HIV epidemic in Vietnam is still currently perceived to be at the concentrated stage with a high prevalence among high risk groups – injecting drugs users (IDU), female sex workers (FSW), and men having sex with men (MSM)[8] – and a low prevalence in the general population, the Government's response has largely focused on these high risk groups, especially young male drug users.[9] However, this characterization of the HIV epidemic has often created a false sense of security and apathy among public health officials of Vietnam. Among the Vietnamese public, this characterization suggests a comfortable distance between "us" ordinary people and "them" who engage in risky behaviors. In their 2008 article, Nguyễn and colleagues highlighted the fact that the risk of HIV transmission among women in Vietnam was largely underestimated. In their view, the reported number of infected women might represent only 16% of actual cases, and the number of HIV-infected women in 2005 might be 98,500 instead of 15,633 cases as reported. It means that in 2005 as many as 83,000 Vietnamese women with HIV were not detected by the health care system, thus the risk of silent transmission, including mother-to-child transmission,

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[7] UNAIDS, "HIV and AIDS Estimates (2009)" at http://www.unaids.org/en/Regionscountries/Countries/VietNam/. Accessed November 27, 2012.

[8] In 2011, PEPFAR reported that injecting drug use has remained the main behavior contributing to the spread of HIV in Vietnam. Though the national HIV prevalence is only 0.43% for ages 15-49, it is much higher for at risk populations. HIV prevalence among IDU is estimated at 40%, even higher in the major cities. HIV prevalence among sex workers, both street-based and venue-based is average at 16% in larger cities. Data also show a growing HIV epidemic among men who have sex with men, especially in Hanoi and Ho Chi Minh City. HIV prevalence is much higher for sex workers and MSM who are also injecting drug users. "PEPFAR Vietnam Operational Plan Report FY 2011" at http://www.pepfar.gov/documents/organization/199703.pdf. Accessed November 27, 2012.

[9] See for instance, "The Third Country Report on Following Up The Implementation To The Declaration Of Commitment On HIV and AIDS," Reporting Period: January 2006 – December 2007. Hanoi, January 2008. At http://data.unaids.org/pub/Report/2008/viet_nam_2008_country_progress_report_en.pdf. Accessed November 25, 2012.

of the deadly virus.[10]

In the early years of the epidemic, the disease known as SIDA (the French acronym for AIDS) was identified with the emaciated bodies of young men who were covered with sores and completely debilitated. As the disease first appeared in densely populated areas of major cities, the public reaction was largely fear, aversion and paralysis. Because Vietnam has a universal health care system – though grossly under funded and inadequate – the often overcrowded public hospitals have to attend to patients upon request. During the earlier years of the outbreak, large numbers of AIDS patients admitted to public hospitals did not receive any form of care from the hospital staff once they were diagnosed with the deadly disease. Because of the horror it provoked and the social stigma that quickly became pervasive, many patients were abandoned by their own families, or thrown out of their homes. They literally wasted away and perished in the streets, in hospital beds, or more often on the hospital floor, from complications of AIDS. This occurred until late 2004, when antiretroviral medicines became available through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). In addition, because a large percentage of injecting drug users were homeless youths, many AIDS victims were found lying debilitated on city streets, in dark alleys, or at the market places. The name "SIDA" was associated with such horrific images that it quickly became a taboo word among the Vietnamese public. One popular Vietnamese saying arose during these years,

[10] Thu Anh Nguyen et al, "A Hidden HIV Epidemic Among Women in Vietnam" *BMC Public Health*, 2008. The usual routes of transmission to women include "sharing needles and syringes with IDU partners, or by having unsafe sex with clients, husbands or lovers." There is a diversity among women infected with HIV, though many new infections among women "can be traced to sexual relations with young male injecting drug users engaged in extramarital sex. Each of these groups may need different interventions to increase the detection rate and thus ensure that the women receive the care they need."

"Sida là xa đi!" which literally translates, "If it's SIDA, stay away!" For good reason, in recent years, Government agencies and health workers in Vietnam have avoided the term "SIDA" and adopted the combination "HIV/AIDS" to indicate both the virus and the disease.[11] Due to lack of specialized care in the earlier years of the outbreak, once the disease manifested itself in patients, the prognosis was between a few weeks and a few months. For this reason, care for HIV/AIDS patients during those years meant palliative care for dying persons and providing for the funeral needs after their departure.

Since 2004, PEPFAR has been the largest program to provide resources for the fight against HIV/AIDS in Vietnam. During the first phase between 2004 and 2008, PEPFAR funded the health services, including prevention, testing, care and treatment for HIV infected persons largely through the agencies of the Vietnamese Government.[12] During the fiscal year 2011, PEPFAR provided antiretroviral treatment (ARV) to 36,200 individuals, care for 113,300 HIV-positive individuals against opportunistic infections, support for 8,600 orphans and vulnerable children, HIV testing and services for 457,200 pregnant women, antiretroviral prophylaxis for 1,300 HIV-positive pregnant women for prevention of mother-to-child transmission, counseling and testing for 710,900 individuals.[13] PEPFAR currently funds nearly 88% of Vietnam's HIV/AIDS response,[14]

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[11] The shortened form of HIV/AIDS in Vietnam is "H" pronounced "huk" by Vietnamese. The more discrete way to refer to the diagnosis is to say "bị nhiễm H" or "infected with H". It is apparent that many health workers also avoid using the word "AIDS" when referring to particular patients.

[12] PEPFAR, "Partnership to Fight HIV/AIDS in Vietnam" at http://www.pepfar.gov/documents/organization/199581.pdf. Accessed November 27, 2012.

[13] Ibid.

[14] The amount Vietnam received through PEPFAR from 2009 to 2011 was $272.5 million for its prevention, treatment and care programs. PEPFAR Vietnam Operational Plan Report FY 2011at http://www.pepfar.gov/documents/organization/199703.pdf. Accessed November 27, 2012. According to *The Third Country Report on Following Up The Implementation To The Declaration Of Commitment On*

while the Vietnamese Government contributes 2%, and the remaining comes from the Global Fund and other donors.[15] PEPFAR provides antiretroviral (ARV) medication for over 60% of patients, both adults and children, currently on treatment. PEPFAR has also been supporting methadone programs for opioid users. Currently, PEPFAR Vietnam is working with the Vietnamese Government to develop a transition plan that aims to increase the national ownership of the prevention and treatment programs,

> As PEPFAR Vietnam gradually moves from direct service delivery to a technical assistance model, careful planning and continual advocacy for financial national ownership will be a critical element to a smooth transition and sustainability. PEPFAR Vietnam identifies a five to ten year window of opportunity to have a significant impact on capacity development of national health systems.[16]

As of the end of November 2012, though ARV medicines are still available through PEPFAR, significant cutbacks in financial resources for prevention and treatment have already occurred in Vietnam. The current concern of many health workers in Vietnam is the abrupt withdrawal of PEPFAR assistance and the gap being left unfilled by the Vietnamese Government that can lead to the discontinuity of life-saving medicines for tens of thousands of adults and children living with HIV in Vietnam.

5.2.2. The Birth of a Catholic AIDS Care Clinic

HIV and AIDS, "The Central Government budget allocation for the AIDS programme was US$ 5 million in 2006 and has been increased to US$ 9.4 million in 2007. Besides the budget provided by the central government to the provinces, local authorities are responsible for mobilization of additional resources for implementation of HIV programmes. However data for funds raised at the local level are not available for the reporting period." Reporting Period: January 2006 – December 2007. Hanoi, January 2008. At http://data.unaids.org/pub/Report/2008/viet_nam_2008_country_progress_report_en.pdf. Accessed November 25, 2012.

[15] "PEPFAR Vietnam Operational Plan Report FY 2011" at http://www.pepfar.gov/documents/organization/199703.pdf. Accessed November 27, 2012.

[16] Ibid.

Phú Trung Clinic is a Catholic outpatients facility which provides medical consultation, treatments and financial assistance to AIDS sufferers in a north-western suburb of Ho Chi Minh City. Located at the back of the parish church, the clinic was set up in 2006 by a Catholic lay woman, Ms Nguyễn Thi Vinh with the support of the local pastor. The chief medical doctor here is Catholic priest Fr Nguyễn Viet Chung, MD, who has worked tirelessly for patients with leprosy, and AIDS patients. Each morning, thirty to forty patients from different parts of the city and beyond come to this church clinic for health consultation and care. Within the last two years at this location, the clinic has cared for over 1,100 patients. Ms Nguyễn Thi Vinh recalls how her small team of volunteers was formed in November 1999, primarily to care for AIDS patients who had been abandoned by their families. In the earlier days, many AIDS sufferers were picked up from the streets and from public hospitals where they received no care. Her team would then bring them home and bathe, clothe and feed them. If they were going to die, Ms Nguyễn explains, at least they would die as human beings…[17]

While the public response to the earliest AIDS sufferers was one of aversion and paralysis, it was the Catholic Church of Vietnam that took the leadership role in the care for these social outcast. By providing active care and support to AIDS patients, the Vietnamese Church has helped transform the way they are received and treated by the Vietnamese society. While the Catholic response to the AIDS crisis in many countries has at times been overshadowed by controversies regarding sexual morality and condom use, the Vietnamese Church has responded to the epidemic with a disarming sense of compassion and solidarity with the AIDS sufferers.[18] As the epidemic became

[17] Notes from my fieldwork in August 2008.

[18] Though at the grassroot levels, there were also prejudice and discrimination against HIV-infected persons among Vietnamese Catholics, the directives of the Church leaders based on compassion prevailed. In his training courses on the service and prevention of HIV/AIDS for Vietnamese clergies and religious, Monsignor Robert J. Vitillo, president of Catholic HIV/AIDS Network outlines both the Church's critique of "safe sex" campaigns across the globe and evidence that condom use for serodiscordant married couples did help reduce transmission rate significantly. He concludes, "In all fairness, when the HIV-positive

widespread, Vietnamese Catholics, religious and lay, women and men, bishops and priests have shown these marginal persons the hospitality and mercy reminiscent of the response of the early Christians to the plague victims in 2nd century Roman cities while the pagans fled and deserted them.[19] In his earlier pastoral letter, Cardinal John Baptist Phạm Minh Mẫn, Archbishop of Ho Chi Minh City, urged Catholics to respond to the AIDS victims by referring to the parable of the Good Samaritan who reached out to one who lay half dead by the road. In his 2006 pastoral letter on the AIDS crisis, Cardinal John wrote to persons living with HIV/AIDS with the words of Isaiah 43:1-4, "Do not fear, for I have redeemed you; I have called you by name, you are mine. When you pass through the waters, I will be with you… Because you are precious in my sight, and honored, and I love you."[20] This most senior Catholic leader of Vietnam urged the

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husband uses condom to protect his wife from infection, it is an act of prophylaxis, rather than contraception. The contraceptive effect in this case is the undesirable side effect rather than a violation of the Church's moral teachings… If the wife or husband is HIV-positive, the use of condom to protect whom ever they have intercourse with is to help reduce the evil effect of a morally wrong act." From course notes distributed in Vietnamese, "*Công bằng mà nói, chồng có HIV, dùng bao cao su để vợ không bị lây HIV, hành động này là để ngừa lây nhiễm chứ không phải là không ủng hộ sinh sản. Việc không có con lúc này là tác dụng phụ không mong muốn chứ không mang ý nghĩa chống thụ thai nếu xét theo quan điểm đạo đức… Nếu vợ hoặc chồng đã có HIV thì việc dùng bao cao su là để ngăn ngừa siêu vi HIV lây lan – với người quan hệ tình dục với đủ loại người không phân biệt thì dùng vao cao su là để giảm những hậu quả xấu do hành vi đạo đức xấu*." Course notes by Robert J. Vitillo, *Tập Huấn Mục Vụ Ứng Phó với HIV và AIDS* [A Pastoral Response to HIV/AIDS], Hanoi, 2008, p. 40. This is significant because, as Y-Lan Tran pointed out in 2008, the Catholic Bishops was largely silent on the issues of condom use, for instance, in serodiscordant couples, and of needle exchange in HIV prevention. See Y-Lan Tran, "HIV/AIDS in Vietnam" in Mary Jo Iozzio (ed), with Mary M. Doyle Roche & Elsie M Miranda, *Calling for Justice Throughout the World : Catholic Women Theologians on the HIV/AIDS Pandemic*, (New York : Continuum 2008), 31-37.

[19] William H. McNeill, *Plagues and Peoples*, (New York: Anchor Books, 1976, 1998), 136. Rodney Stark, *The Triumph of Christianity: How the Jesus Movement Became the World's Largest Religion,* (New York: Harper Collins, 2011), 105-120. See also Darrel W. Amundsen & Gary B. Ferngren, "Virtue and Medicine from Early Christianity through the Sixteenth Century" in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (D. Reidel Publishing Co.: Dordrecht/Boston/ Lancaster, 1985), 49-59. Some details of the early Christians' response can be found in Eusebius, *Church History*, Book VII, Chapter 22, (7) and (10).

[20] Hồng Y Tổng Giám Mục Gioan B. Phạm Minh Mẫn, Lá Thư Mục Tử, 2-6-2006 in Nguyễn Đăng Phấn, Nguyễn Đình Thao, Đoàn Quốc Anh, Uông Thị Nhu Hương (eds), *AIDS Và Lòng Tin: Người Công Giáo Việt Nam Đối Diện Đại Dịch HIV/AIDS*, [Catholics Facing the AIDS Pandemic] (HCM City: Vòng Tròn

faithful to "continue Christ's mission on earth" by caring for those who were suffering, especially persons living with HIV/AIDS who needed love and care the most.[21] With great sensitivity and compassion, the Cardinal called on Christians to respond to the epidemic by accompanying "the mothers, the widows, the young persons, the orphans who are living on the verge of despair because of this devastating disease."[22] He called for the formation of a new community of solidarity and love, in which the phenomenon of HIV/AIDS will no longer be considered a curse from God, but an opportunity for growth in God and toward God.

The Cardinal's prophetic leadership in response to this crisis has been providing much moral support to persons like Ms Nguyễn Thị Vinh in the fight against HIV. Furthermore, the story of Ms Nguyễn Thị Vinh and her team itself embodies the leadership of Catholic lay persons in the face of this health crisis. Her story began at the Advent retreat in 1998 at the Redemptorist Church in Ho Chi Minh City, when Fr Vũ Khởi Phụng, C.Ss.R. made an appeal to the congregation for help in the care for AIDS patients who were being abandoned in the government-run hospitals. It was the word "*abandoned*" that stayed with Ms Nguyễn, and moved her to volunteer herself to help those "abandoned" victims. After receiving an intensive training course by Catholic surgeon Dr. Nguyễn Đăng Phấn on the care for HIV/AIDS patients at a facility of that same Church, Ms Nguyễn and nine other volunteers began their work with AIDS patients. Most of them, including Ms Nguyễn, had no medical background, and had very

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Đồng Tâm, 2007), 24.

[21] Ibid., 25.

[22] Ibid.

limited understanding of HIV/AIDS. Nevertheless, they persevered out of "a desire to help the unfortunate patients who suffered extreme poverty and despair because of the *death sentence* brought by this incurable disease."[23]

The ten volunteers agreed to form a group and began to reach out to the AIDS patients who were forsaken in the public hospitals: Bình Dân Hospital, Phạm Ngọc Thạch Tuberculosis Hospital, Hospital for Tropical Diseases, and others. They also attended to homeless patients who lay helpless on city streets or under bridges. At the feast of Christ the King in late November 1999, the group decided to put itself under the patronage of Christ the King, and chose the name Nhóm Tiếng Vọng [Team Echo] for their group as a response to the cry of Jesus, "I thirst" on Calvary. As members of the team quietly went out to find and care for HIV infected patients, their perseverance gradually attracted other volunteers to the work. After five years of service (1999-2004), their team grew to twenty five members. As Ms Nguyễn relates, "Our sole motivation has been Christian charity, or the desire to love and serve Christ in the patients who suffer in poverty, rejected and abandoned by their own families." She writes,

> *Our team members served in a selfless way, willing to sacrifice time, energy, and money to go out to the city streets to look for and offer care to those patients who were covered with sores, who lied lonely and desperate waiting for death on the hospital floor, in the gutter, at the dark corners of markets, or by the sewer canals*.[24]

Members of their team included college students, factory workers, religious women and men, doctors, and also some HIV sufferers themselves who had been assisted by the team. They were of vastly different backgrounds, family circumstances and ages, but

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[23] Notes from Ms Nguyễn Thị Vinh in 2011 through correspondence. Also Ms Nguyễn Thị Vinh, "Tự Bạch" in Nhóm Tiếng Vọng, *Yêu Cho Đến Cùng*, Đặc San 5, 2004, 46-49.

[24] Ibid.

came together for a common goal. Their social mission also attracts volunteers of other religious affiliations. New members were given training on patient care: to give medicines, to feed debilitated patients, to attend to their toilet needs, to wash and change their clothes, to give haircuts and to clip their finger and toe nails, to cool febrile patients, and to ask patients about their needs. In the earlier years before ARV medicines became available through PEPFAR, much of their work was care for dying patients. Facing the threshold of death, health care and pastoral care began to merge. If the dying person was Catholic, team members would come with the priest for the last rites, and to say prayers for the dying. When the patient died, if the family was below poverty line, the team would also take charge of arrangements for the funeral, often by asking others for support. The team would attend to dying persons of non-Catholic background in a different way:

> *If the patient was not a Catholic, we would quietly come and make the sign of the cross and kiss their forehead, whispering in their ear, "Brother (or sister), have a safe journey. Our loving Father is waiting for you, and when you meet with Him, please tell Him that we, your brothers and sisters here on earth, put our complete trust in Him." If they left this world without any relatives, we would ask others for support with arrangements for the funeral*.[25]

Ms Nguyễn also undertook further training courses on AIDS care provided by UNICEF in Hanoi (2002), and by the Ho Chi Minh City Provincial AIDS Committee in cooperation with the international health network ESTHER (2004).[26] In 2004, the team decided to find a location for gathering patients together for ongoing care in order to reduce the amount of travelling they had to do from one health institute to another. They

[25] Ibid.

[26] ESTHER stands for "Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau."

rented a house on Lê Văn Quới Street, Bình Tân District and used it as a facility for patient care. After some time, they ran out of funds. In late 2004, Ms Nguyễn Thị Vinh made the bold decision to bring patients to her family home for care, despite the small size of the inner city house which she shared with her husband and children within a crowded neighborhood. The number of patients quickly grew. Each morning, dozens of patients came for consultation and treatment, for intravenous albumin infusion, and for medicines. In the afternoons, the team would go out to attend to homeless patients or to do home visits.

Before long, care for HIV/AIDS sufferers at Ms Nguyễn's private home caused much reaction among the neighbors. On January 2, 2006, with the support of the pastor of Phú Trung Catholic Parish, the AIDS care clinic was moved to a facility within the Phú Trung Parish Church Compound. At this new location, the team currently provides general consultations to attend to health needs, occupational needs, nutritional needs, legal needs, and counsel on HIV prevention for patients and their relatives. Team members also engage in HIV prevention by tracing contacts of infected patients, and advise them to get tested. During my visits in 2008 and 2011, I was touched by the number of patients who received medical services at this Church clinic, and the diverse range of illnesses and complications of AIDS that Ms Nguyễn and her team were able to handle effectively with the basic training they received and the limited resources at hand.[27] Patients who receive ARV medicines – and very little care – from government-run facilities come to this Church clinic where they receive treatment for malnutrition, for

[27] In 2008, Fr Nguyễn Viet Chung, M.D. served on a part-time basis at this clinic as a medical consultant, but left a year later to provide health services in a lepers' shelter in a remote northern province.

tuberculosis and opportunistic infections such as fungal meningitis, bacterial meningitis, skin diseases, and gastroenteritis. Apart from the room being used as both the consulting room and the dispensary, there were two other rooms with a total of twelve to fifteen treatment beds available for wound care, intravenous antibiotics, or albumin infusion for debilitated patients. The clinic has been funded by the local parish and by donors at home and abroad. Many volunteers also came to assist with patient care; some volunteers were former patients at this clinic. Within two years after the clinic moved to the present location, there were more than 1,100 patients being assisted by the team. Some patients travelled great distances, sometimes three to four hours from nearby provinces, to receive care at this center. Patients readily responded to Ms Nguyễn's holistic approach to AIDS care, and their appreciation and trust in this community health worker was apparent. At each of my visits, Ms Nguyễn who knew of my medical background, would discuss with me about the difficult cases that she faced. It emphasized for me her ongoing need for medical support in this challenging work.

In the afternoons, the team would engage in outreach work by visiting AIDS patients in their homes. They also support homeless patients in cooperation with specialized centers, such as Mai Hòa Shelter or Nhân Ái Hospital. The team also assist children infected with HIV from birth, or orphans of persons who have died of HIV/AIDS. They provide nutritional supplements: packages of rice, noodles, and milk for adults and children affected by HIV/AIDS who live in poverty. During ten years between 1999 and 2011, the team cared for almost 5,000 patients with HIV/AIDS. By the end of the ten years of service, a third of their patients had died. This also means that a large number of patients are still alive because of the medical care they receive at Phú

Trung Clinic. Even with ARV medicines and vigorous treatment for opportunistic infections and complications, a significant part of their work is still palliative care for dying patients. Ms Nguyễn wrote, "*Through experience, we recognize that AIDS patients, especially those at the final stages of their disease, really need the understanding, love and acceptance of their loved ones so that they may go in peace*." Ms Nguyễn and her team also come to a conviction that, "*in helping the patients, we also help ourselves grow, come closer to God, and do our part to stop the spread of this epidemic*." Ms Nguyễn's conclusion captures the faith dimension that has sustained her and her team,

> *We have shared with the patients as far as our capacities would allow, in response to their material and psychological needs, so that they could live with a more positive outlook, to return to an ordinary life as a member of the community like ordinary persons, without being condemned or despised. Above all, my greatest desire has been to give them a witness to the faith in Christ, who suffered like them, who died and rose again. Over the years, many patients have found hope in Him.*[28]

The sense of mission is at the core of this Catholic lay group. Their work in restoring infected persons to health, to relationships, and to participation in community life powerfully mirrors the healing work of Luke's Jesus. If Christ's healing ministry provides vision and directives for Christian health workers, his suffering, death, and resurrection provide hope in the fight against this deadly virus. The story of Ms Nguyễn and her team also powerfully illustrates the link between personal virtues, the community that is formed by a shared goal, and social action on behalf of the most vulnerable in society. It is the story of a Catholic lay person prompted to action by her compassion for abandoned AIDS victims, responding to the invitation of Christ to show mercy to others

[28] From Ms Nguyễn Thị Vinh's personal reflection on her work, communicated by correspondence in mid 2011.

through concrete action. Her personal response then led to the formation of a group that is specifically devoted to the service of today's social outcast. The works undertaken by Ms Nguyen's team for AIDS sufferers and their families are motivated by mercy and Christian charity, as Ms Nguyen herself relates, "Our sole motivation has been Christian charity, or the desire to love and serve Christ in the patients who suffer in poverty, rejected and abandoned by their own families." It is significant that their health services, education for harm reduction, accompaniment and counseling, advocacy, and support for vulnerable persons, also have strong *social* significance, because they not only provide direct care and support for patients, but also help address the injustice suffered by AIDS victims.

5.2.3. A Concerted Catholic Response – The Mai Linh AIDS Care Community

Perhaps the most emblematic of the Catholic response to the AIDS crisis in Vietnam is the Mai Linh Community which consists of religious women and men being sent from a variety of orders and congregations to care for AIDS patients.[29] The origin of this response is a witness to the leadership role of the Catholic Church in the face of public aversion and paralysis. In February 2004, Mr. Lê Thành Tâm, the Head of the Department of Social Affairs of Ho Chi Minh City (*Sở Lao Động, Thương Binh và Xã Hội TP Hồ Chí Minh*) sent a request to Cardinal John Baptist Phạm Minh Mẫn asking for assistance from the Catholic Church in the care for AIDS patients in Ho Chi Minh City.[30]

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[29] The name Mai Linh brings together the two words "Mai" (Vietnamese reference to Our Lady "Mary") and "Linh" ("Thánh Linh" for the Holy Spirit).

[30] In this section, I grateful to Mr. Do Tan Hung for providing me with much information, some of which is from his own immersion experience to Vietnam in 2006. His memoir in Vietnamese, *Những Nẻo Đường Việt Nam* [The Roads of Vietnam] is available at

In response, Cardinal John invited religious congregations to send women and men to undertake this challenging task. In early May 2004, religious women and men from sixteen congregations volunteered for this project, and they formed the Mai Linh Community to serve AIDS patients at the Focal Point Detoxification Center (*Trung Tâm Trọng Điểm Cai Nghiện Ma Túy*), some 200 km North of Ho Chi Minh City in a remote area. The facility was set up by the Ministry of Health as a response to the AIDS crisis in Ho Chi Minh City. However, as the Head of the National Commission on AIDS – Ho Chi Minh City said on the reception ceremony of the religious sisters to the Center in May 2004, though the Government had resources and staff, it lacked "persons with compassion and the spirit of services similar to Catholic religious persons."[31] More recently, the facility has been significantly upgraded and better equipped to become a specialized hospital for AIDS care, by the name Bệnh Viện Nhân Ái [Nhan Ai Hospital].[32] Members of the Mai Linh community are religious women and men, many are young and still in formation, and Catholic lay persons who volunteer for this work. Since 2004, as ARV medicines and the methadone programs became available through PEPFAR, the services provided at this Center have included long term care, treatment for opportunistic infections, tuberculosis management, and a detoxification program. The residents of this Center, around 300 in number, are largely young men and women with

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http://www.dunglac.org/index.php?m=module2&v=chapter&id=50&ib=197&ict=1396. Accessed November 24, 2012.

[31] UCA news, "Vietnam: The Local Church Trains Personel to Serve HIV/AIDS Persons," in Nguyễn Đăng Phấn, et al (eds), *AIDS Và Lòng Tin: Người Công Giáo Việt Nam Đối Diện Đại Dịch HIV/AIDS*, [Catholics Facing the AIDS Pandemic], 67.

[32] The two words that make up the name of this hospital are grounded in Confucianism: "nhân ái" in Chinese *rén ai* 仁愛 mean "humaneness and love." Though this has been an AIDS care facility, for the reason of discretion, no reference to this disease is made in the institution's original name, or the more recent name.

HIV/AIDS and a history of drug addiction, who suffer from a range of complex health problems: from physical illness to maladaptive behavior, from fractured relationships to psychological issues, from deep hurt and anger to shame and despair. During the course of their treatment the more able residents are encouraged to engage in some form of manual labor.[33] Under the guidance of religious men and women, the residents either tend vegetable gardens, grow crops and raise animals, or engage in handy crafts to create rosaries, greeting cards, or beads work. Apart from the small amounts of income they generate, these works are also therapeutic for the young residents, providing a healthy focus for their time and energy.

Because of the demanding nature of the work, there is a regular turn-over of staff, with new members coming to replace older members every six months. The sense of mission and service is palpable among members of this healing community. A sister from St Paul de Chartres Congregation shared,

> *Initially, I broke out in cold sweats and lost my appetite for days when I saw the gaping sores and smelt the odor of patients. But now I am used to it; I have more courage… My courage comes from God's love, which has strengthened me to continue serving these abandoned brothers and sisters of mine*.[34]

Another sister, of the Missionaries of Christ's Charity, said, "*I could contract the virus as I serve the patients here, but that is not important because I want to serve the Church's mission*." This dedication to the mission is shared by many of the Mai Linh Community.

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[33] As is the case with Catholic-run AIDS care shelters in Ho Chi Minh City, manual labor is often part of the daily routine for more able persons. Mai Hòa Center for unsupported persons with HIV/AIDS in Củ Chi District, and Mai Tâm Shelter for orphans and widowed mothers with HIV/AIDS in Thủ Đức District each has a workshop for residents.

[34] UCA news, "Vietnam: The Local Church Trains Personel to Serve HIV/AIDS Persons," in Nguyễn Đăng Phấn, et al (eds), *AIDS Và Lòng Tin: Người Công Giáo Việt Nam Đối Diện Đại Dịch HIV/AIDS*, [Catholics Facing the AIDS Pandemic], 65-68. See also Ban Mục Vụ Chăm Sóc Người Có HIV/AIDS Tp Ho Chi Minh, *Nhật Ký Ra Khơi,* Archdiocese of Ho Chi Minh City.

One significant feature is the place of the Eucharist in the life and work of this healing community. In 2006-2008, as Fr Nguyễn Viet Chung was serving as the consulting physician at Phú Trung Clinic, he went to the Focal Point Center to celebrate the Eucharist and administered the sacraments for the Mai Linh Community and the residents on a regular basis. The Eucharist sustains these dedicated women and men, and gives them the courage they need to continue their service among this marginalized group of persons. Their selfless service has brought healing to many, in more ways than one. The atmosphere of acceptance, of mercy and love created by this religious community is itself a witness to the gospel of healing. A young resident wrote,

> *As I saw the Sisters caring for me with the dedication of a mother, my heart was filled with emotions. I wanted to kneel down in front of my mother asking for her forgiveness, for she has sacrificed so much to bring me up and has forgiven me numerous times for my mistakes. Currently, though I still have the disease in me, I am comfortable and happy. I thank the Sisters who have helped me overcome my life crisis*.[35]

His words communicate peace and security after much internal turmoil and self-alienation. The prospect of restored relationship with his own mother now seems possible. Another resident said, "*I hope to recover quickly, and to go through the detoxification program fast so that I can make a new start for my life*." A number of former residents, after their recovery, have volunteered to serve other residents at the Center as staff assistants.[36] The works of Mai Linh Community bear powerful witness to Luke's Jesus who reached out to the social outcast and restored them to health, to human dignity, to relationships within the community. They also prove that there is hope of

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[35] Ibid.

[36] Ibid.

renewal even for the most broken and despised of today's society.

5.2.4. The Orphans and Widows of the AIDS Epidemic – Mai Tâm Shelter

Mai Tâm House of Hope (Mái Ấm Mai Tâm) is a shelter for HIV- infected children and unsupported mothers with young infants in Thủ Đức District, on the northern outskirt of Ho Chi Minh City.[37] Many children at Mai Tam are living with HIV/AIDS, others are the children or orphans of persons with HIV/AIDS. Mai Tam – the first and still the only facility of its kind – was established in 2005 by Fr. John Baptist Phương Đình Toại, M.I. under the auspices of the Archdiocese of Ho Chi Minh City. Fr Phương began this work after his first encounter with a distraught Vietnamese woman in Thailand who found herself pregnant and tested HIV positive. Upon his return to Vietnam, the newly ordained priest founded the shelter to care for infants of HIV-infected mothers, who in many cases had neither the means nor the family support to raise their children. As his work became known, many HIV-infected pregnant women have been referred to Fr Phương, who would accompany them through the birth of their child, then assume care for their newborn. Though mother-to child infection is prevented in many cases through ARV prophylaxis, some children are infected at birth and require life long treatment. Some children at Mai Tam have been abandoned by their families because of HIV/AIDS and referred to Fr. Phương. Some were found in the streets. Others were abandoned at

[37] From personal interviews with Fr John Phuong Dinh Toai and the staff at Mai Tam in August 2008. Also Kim Lê, "Mái ấm Mai Tâm với 60 em bé bị nhiễm HIV / AIDS tại Saigòn" URL: http://danchuausa.net/giao-hoi-viet-nam/mai-am-mai-tam-voi-60-em-be-bi-nhiem-hiv-aids-tai-saigon/ Accessed Nov 24, 2012. And www.maitamhouseofhope.com. Accessed November 24, 2012. I was delighted to be involved in a fund-raising event for Mai Tam, organized by Robert and Jill Morris and Dr Que Dinh at Phở Hòa Vietnamese restaurant in Dorchester on November 29, 2012 during the visit of Fr John Phương Đình Toại to Boston.

Buddhist temples, and subsequently referred to Fr. Phương by Buddhist monks. During my visit in 2011, Fr. Phương spoke of his work of accompaniment of HIV-infected mothers, some were young women involved in sex work or escort services.[38] Once the women became pregnant, people of clandestine adoption rings would offer them a sum of money if they agreed to give up their newborn infants for adoption. These adoption "agents" would then give the infants, many are HIV-infected, to unsuspecting couples for adoption in exchange for a larger sum of money, making a profit for themselves.[39] Once the expecting mothers were referred to Fr. Phương, he would advise them not to "sell" their infants, but to give them to his care instead, because at least the mothers would know that their infants were well cared for, and would have the option of visiting, or requesting him to assume care for their children. Fr. Phương's policy is that only HIV-negative children can be given to couples for adoption, because HIV-infected children require the specialized care that ordinarily cannot be provided by inexperienced foster parents. For mothers who want to care for their HIV-infected children, Fr. Phương would provide guidance and support through the outreach and follow-up programs. Because of his work, Fr. Phương has been hassled or threatened by the clandestine adoption agents who want to protect their business.

When Mai Tam was first established, it was subject to much harassment in its

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[38] In her article (2011) based on her seven months of field research, Kimberley Kay Hoang gives very good insights into "three racially and economically diverse sectors" of sex work in Ho Chi Minh City. She describes "a *low-end sector* that caters to poor local Vietnamese men, a *mid-tier sector* that caters to white backpackers, and a *high-end sector* that caters to overseas Vietnamese (*Viet Kieu*) men." Kimberley Kay Hoang, ""She's Not a Low-Class Dirty Girl!": Sex Work in Ho Chi Minh City, Vietnam" in *Journal of Contemporary Ethnography* (2011), 40(4), 367–396.

[39] The usual amount paid to the women is about USD $200, and the fee the foster parents would pay is around USD $500.

neighborhood because of the stigma associated with HIV/AIDS. In 2009, Mai Tam was moved to a new building at the current location in Thủ Đức, with the help of generous donors. Mai Tam currently has a number of classrooms for children, and an infirmary. There are also additional facilities: a home for infected widowed mothers and their children, and a staffed home for adolescents who are capable of semi-independent living.[40] Mai Tam is currently providing shelter for 77 orphans, 24 widowed mothers with young children, and supporting 550 families affected with HIV/AIDS through its outreach programs. Despite the social stigma, Mai Tam has successfully placed 30 children in kindergartens and primary schools. Mai Tam is supported by a large number of volunteers including baby sitters, cooks, tutors, and infirmarians. There is a workshop for women that produces children's clothes, diapers, women's dresses, cloth masks, and wedding dresses. The children's affection for Fr. Phương is enormous, reflecting his care and commitment to each child. There is a warm family atmosphere at Mai Tam, where older children share the responsibility of caring for the younger ones. Mai Tam is indeed the house of hope, for it provides shelter, treatment and support to children and women, the most vulnerable victims of the AIDS epidemic in Vietnam.

5.3. FROM EXCLUSION TO SERVICE: THE CONTRIBUTIONS OF CATHOLIC AIDS CARE NETWORK OF VIETNAM

K. is a young mother, in her twenties, who comes to Phú Trung Clinic from Tây Ninh, a

[40] More information can be found on www.maitamhouseofhope.com.

Province 50 miles north west of Ho Chi Minh City. Her husband died of AIDS one and a half years ago. He was a tradesperson who travelled frequently to the City. Then he fell ill over a number of months, losing weight, had swollen glands and high fevers. One day, he told K. with a very sad look, that he feared he might have AIDS. That was when K. discovered that her husband had been with prostitutes, and recently had also begun injecting drugs. Doctors confirmed that he had AIDS. Within three months, he became progressively ill and passed away. Soon afterward, K. fell ill and doctors informed her that she had contracted HIV from her husband. Her 4 year old son was also tested, and luckily, he was not infected. When speaking of her son, K's sad face suddenly brightens up. When her husband was still alive, they used to live with her husband's parents. Now, her mother in law would not look after her, K. has to bring her son back and live with her own parents. Currently, the household is living on the income of her father who earns 50,000 VND ($3USD) a day from manual labor. The outreach program at Mai Tam Center also provides K. with 150,000 VND ($9 USD), and a container of milk each month. Her mother who brought her to the clinic, says that though suffering from this disease, K. is at least comforted by the thought that she herself was not the cause of her current illness.[41]

James Keenan identifies mercy as the defining virtue of early Christianity, when Christians gave of their resources, sometimes putting their own lives at risk, to help immigrants and the sick in crowded Greco-Roman cities.[42] As historians Amundsen and Ferngren see it, Christianity from its conception has perceived the duty to care for the poor and the sick as an indispensable part of its mission.[43] During the times of epidemics, the Christian zeal to care for the suffering was most evident, and contributed

[41] Interview notes from my fieldwork in 2008.

[42] Keenan, *The Works of Mercy,* 4-5.

[43] Darrel W. Amundsen & Gary B. Ferngren, 'Virtue and Medicine from Early Christianity through the Sixteenth Century' in Earl Shelp (ed), *Virtue and Medicine: Explorations in the Character of Medicine*, (Dordrecht/Boston/ Lancaster: D. Reidel Publishing, 1985), 49-59.

significantly to the rise of Christianity. Into the twenty-first century, Christian women and men, lay, religious and clergy of Vietnam have responded to the distinctive call of Christ during times of crisis when afflicted human persons are suffering in loneliness and despair. In the midst of society's aversion and paralysis when confronted with the AIDS crisis, they offered a way forward, breaking through the barriers of social stigma and blame. They responded by first providing care and support for infected persons, who have been driven out of their homes by their own kin, and ostracized by society. As has been the case in many places across the globe, HIV/AIDS presents a threat to the Vietnamese civil society, and the public response has been to put up shields "that keep vulnerable and most at-risk individuals marginalized and distanced from 'the general population,' or those that are perceived as protecting social mores and orthodoxy from contamination."[44] By reaching out to these marginal persons, the Catholic health workers of Vietnam have provided the leadership much needed in the fight against this deadly virus. Through their unassuming and persistent services, they have shown health workers, leaders and members of the Vietnamese public that care for AIDS patients is possible, and that exclusion of affected persons is neither the *only* nor an *adequate* response to HIV/AIDS. Their services demonstrate that even with very limited medical training and resources, people can do so much to assist AIDS patients. They have shown that attention to the most basic aspects of patient care such as nutrition and hydration, personal hygiene, and ordinary wound care can significantly improve outcomes for these neglected human persons. The Catholic services at Phú Trung Clinic provide proof that

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[44] James Keenan and Enda McDonagh, *Instability, Structural Violence and Vulnerability: A Christian Response to the HIV Pandemic* (London: Progressio, 2009), 4.

antibiotics for infections, nutritional support, and treatment for tuberculosis are effective in saving the lives of AIDS sufferers, in conjunction with the ARV regimes provided at the public clinics. The Mai Linh Community has shown that healing and return to ordinary life is a possibility even for drug addicts with AIDS, the most despised among today's social outcast. The services of the Mai Tam Center have demonstrated that children of infected mothers can be raised, albeit with much labor great care, through the support of volunteers and donors from within the community, and through networking with others at home and abroad.

Furthermore, by providing care for these marginal persons, the Catholic health workers also enable society to take the first step toward HIV prevention. By helping to change public perception so that care for infected individuals becomes an ordinary and normal part of health care, they encourage members of the public who are more at risk to undergo testing instead of living in secrecy and denial. The Catholic leadership and examples in service have helped society overcome the fear and taboo that are major social obstacles to testing, reporting, and effective management of the outbreak. In addition, by their accompaniment and counseling at the personal level, Catholic health workers have also contributed directly to HIV prevention through education and empowerment of infected persons and their families toward harm reduction, through contact tracing, and through dissemination of information among target groups, especially the injecting drug users and sex workers.

In light of my present studies and dissertation, the Catholic services of AIDS patients in Vietnam powerfully demonstrate a community-based response to this deadly

disease. This Chapter has considered the very complex aspects of AIDS care: from physical to mental health needs, the impact of the disease upon a marriage relationship and family structure, the need to provide shelter and care for HIV-affected infants and unsupported mothers, the provision of education for orphaned children, income-generation initiatives for more independent persons living with HIV, from palliative care to bereavement counseling, and provision for patient's funerals. Unsurprisingly, AIDS care is especially demanding in a developing country like Vietnam, where the poor have no access to adequate health care, social services are absent, and public health education is limited.[45] The Catholic response in Vietnam has been characterized by team work, cooperation, and networking across institutions and agencies. The Catholic health workers have responded to the invitation of Christ, and of the Church leadership, by giving of their time, their labor and resources, even putting themselves at risk, to assist those who are abandoned by society. They respond by forming communities to undertake the mission. They coordinate their works with other health centers within the Catholic AIDS care network, work within the existing structures of society, invite others to take part in the common mission, thus forming support networks at home and abroad. Each of them is a healing community, which by its care and selfless dedication to the welfare of the patients creates a *healing atmosphere* that itself provides shelter for AIDS victims and their families in the face of public prejudice and aversion. Each community in its own way embodies the virtues of mercy, compassion, and hospitality of Jesus the

[45] There are posters displayed on the streets in Ho Chi Minh City that advocate condom use and calling people to undergo testing. These posters themselves largely are funded by overseas donors, such as Family Health International. There are also community-based HIV prevention projects, such as the peer education program for sex workers, Ánh Dương Center, a women health project run by Ho Chi Minh City Women Association (Hội liên hiệp phụ nữ TP.HCM) and supported by Family Health International, at 71 Võ Thị Sáu, P6, Q3, HCM City.

healer. Their works reflect the solidarity of Luke's Jesus with the afflicted who are despised by cast out by society. Their services to help infected persons return to ordinary life mirror God's lifting up of the lowly, and the gathering of God's children by Luke's Jesus. Their holistic approach to care, encompassing physical, psychological, relational, educational, and social needs is in line with Luke's view of God's saving purpose for humanity.

At a different level, the works of the Catholic AIDS care network also demonstrate the *social significance* of the virtues of mercy, hospitality, and solidarity embodied by Luke's Jesus. From a social justice perspective, the works that the Catholic communities undertake for AIDS victims through health services, education for harm reduction, accompaniment, advocacy, and the provision of shelter and support for vulnerable persons with HIV/AIDS, are in fact social actions that contribute to a more just society. Looking through the lens of *Christian charity* – as Catholic workers like Ms Nguyễn Thị Vinh and the religious Sisters of Mai Linh see as their motivation – their services demonstrate the *social impact* of the works motivated by Christian charity, bear powerful witness to the gospel of love. The Catholic health workers become community leaders in the fight against HIV/AIDS because of their Christian love, and the virtues of mercy, hospitality, and solidarity that they show through their works. Looking from the perspective of social justice, in light of the societal causes of illness, their works on behalf of the afflicted represent attempts to remedy a gravely unjust situation, for which members of the wider society ought to bear responsibility. In this light, the Catholic health workers demonstrate the virtue of justice through their works in response to the injustice suffered by the AIDS victims. Their leadership is therefore the leadership of

conscience: helping to awaken others to their sense of justice and responsibility toward the marginalized of society.

In Vietnam's cultural context, the Catholic services also embody Lãn Ông's concern for the poor, and his advocacy for equal treatment for all patients regardless of wealth or social status. Where social stigma and fear have caused paralysis and exclusion from Government-run facilities, the Catholic health workers have shown examples of humaneness in service by putting human lives above profit. In light of Lãn Ông's warning against abandoning critically ill patients out of fear for one's reputation or loss of income, Catholic health workers such as Dr. Nguyễn Đăng Phấn, Ms Nguyễn Thị Vinh, Fr. Nguyễn Viết Chung, Fr. Phương Đình Toại and their teams have stood by their patients and served their needs. Their works strongly illustrate Lãn Ông's conviction about the social responsibility of health workers toward the widows and orphans, who in the Vietnamese cultural context and in the face of the AIDS epidemic are unquestionably the most vulnerable socially and economically. To return to the story of K., the widowed mother who was infected by her husband and driven away by her in-laws, the words of Lãn Ông most powerfully capture the duties of health practitioners, and of the Vietnamese public at large, toward persons in her situation,

> *When very dutiful children, or very dedicated wives become sick in extreme poverty, besides giving free medicines, physicians should also provide for them according to their means, for persons who have medicines but no food to eat also perish. A physician must care for the person's life in its totality to be worthy of the art of humaneness* (*Moral Precept* 8).

When a dedicated wife is infected by her husband, then suffers discrimination and lives in destitute, it leads us to larger questions regarding society's moral norms and the unjust social structures that victimize women and their children. The experiences of HIV

prevention across the globe in the last three decades have identified some complex sociological factors that are also relevant for Vietnam's context. To these we now turn.

5.4. HIV PREVENTION IN VIETNAM'S CONTEXT

T. is a 20 year-old mother, coming here from Rạch Giá, 120 miles south west of Ho Chi Minh City. Her husband contracted the virus from being with prostitutes, then transmitted to her. After his death, doctors discovered that she was HIV-positive, and three months pregnant. Thanks to her doctors who took extra care to prevent mother-to-child infection through the use of ARV before birth, her infant was not infected with the virus. T. has a job that pays 800,000 VND (USD $40) a month, while raising her 18-month-old baby. T. has to borrow for the bus ticket each time she makes a trip to Ho Chi Minh City for treatment.[46]

The dominant modes of HIV transmission in Vietnam are strongly related to social phenomena: prostitution and intravenous drug use.[47] These social issues in turn have their root causes in other social aspects: poverty and increasing classism, the low status of women, homelessness among young people, homophobia and other forms of social discrimination, urbanization and the breakdown of traditional support structures.[48] In recent years, an increasing proportion of new HIV cases in Vietnam have been diagnosed among married women who have contracted the virus from their husband, and among newborn infants of infected mothers.[49] Paul Farmer maintains that, because poverty and

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[46] Notes from my field work in August 2008.

[47] MAP Report: *AIDS in Asia - Face the Facts* (Monitoring the AIDS Pandemic, 2004).

[48] Research Report, "Street Children and HIV/AIDS Issues in Ho Chi Minh City" conducted by the Health Education and Communication Center with support of Save The Children- Sweden, (Ho Chi Minh City: Thế Giới Publishers, 2004).

[49] For this reason, PEPFAR has provided testing for pregnant women, and active interventions given for HIV-positive women. See PEPFAR, "Partnership to Fight HIV/AIDS in Vietnam" at

gender inequality are major contributing factors in the spread of AIDS, the promotion of social and economic rights must be central to HIV/AIDS prevention.[50] The prevention initiatives based on a bioethical framework that emphasizes autonomy and greater access to information are inadequate because they ignore these crucial societal factors that affect health. A social ethical framework is needed to help identify and address the social justice issues such as poverty, lack of education, the low status of women, and discrimination against persons with HIV/AIDS. Cahill maintains that AIDS is primarily a justice issue, because the primary cause of the spread of HIV is poverty, and the related barriers to prevention are "racism; the low status of women; and an exploitative global economic system, which influences marketing of medical resources."[51] As Cahill points out, poverty is linked with poor health, due to lack of access to nutrition, clean water, sanitation, education, perinatal care and primary health care. People living in poverty have no access to the means of preventing diseases. In addition, they are forced to adopt "survival strategies" that expose them to health risks. In a recent article based on field research on sex work in Ho Chi Minh City (HCMC), Kimberly Kay Hoang identifies the three racially and economically diverse sectors of the city's sex industry: "a *low-end sector* that caters to poor local Vietnamese men, a *mid-tier sector* that caters to white backpackers, and a *high-end sector* that caters to overseas Vietnamese (*Viet Kieu*)

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http://www.pepfar.gov/documents/organization/199581.pdf. Accessed November 27, 2012.

[50] Paul Farmer and David Walton, 'Revealing and Critiquing Inequities: Condoms, Coups, and The Ideology of Prevention – Facing Failure in Rural Haiti' in James F. Keenan (ed), *Catholic Ethicists on HIV/AIDS Prevention*, (New York/London: Continuum, 2005), 118.

[51] Lisa Sowle Cahill, "AIDS, Justice, and the Common Good" in Keenan (ed), *Catholic Ethicists on HIV/AIDS Prevention*, 282-285.

men."[52] Hoang found that the women in the low-end sector were "among the most vulnerable and the most exploited," who entered and continued in sex work as a means to escape poverty.[53] Making on average a hundred dollars a month, most women in this sector cannot afford to buy condoms, which cost roughly forty cents each. In addition, women who work in brothels disguised as barbershops rarely carry condoms because if caught by the police, they will be arrested, as prostitution is illegal in Vietnam. Among the clients that Hoang interviewed was a local man – known by the pseudonym Khoa – in mid forties with a wife and a one-year-old son who live in a remote southern village. He left home to work in HCMC with a construction company that pays roughly a hundred dollars per month, and goes to the brothel to relieve the tension of being alone in the city.[54] While sex-for-money exchanges happen in the low-end sector, the "relational exchanges," that take place in the mid-tier sector typically involve "a complex set of intimate and economic arrangements, the exchange of bodily and cultural capitals, as well as short-term client–worker interactions that sometimes develop into long term boyfriend–girlfriend relationships."[55] Hoang found that, as the relationships are transformed into boyfriend–girlfriend relationships, "one way that sex workers expressed care for their boyfriends was by discontinuing condom use."[56] Women who work in the high-end sector are mostly young, well educated, some from wealthy families and move comfortably among the City's elites. The exchanges between them and the clients

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[52] Kimberley Kay Hoang, "'She's Not a Low-Class Dirty Girl!': Sex Work in Ho Chi Minh City, Vietnam" in *Journal of Contemporary Ethnography* (2011), 40(4), 367–396.

[53] Ibid, 378.

[54] Ibid, 379.

[55] Ibid, 372.

[56] Ibid, 384.

"involve a complex set of economic and intimate arrangements and the deployment of economic, cultural, and bodily capitals."[57] Women working in this sector choose their clients, mostly wealthy overseas Vietnamese men, with whom they play a subordinate role in exchange for expensive gifts to support their elitist lifestyle. When they have sex, "the women made the clients believe that they were monogamous partners and could therefore have sex without protection," though most clients being interviewed said they used condoms to avoid getting the women pregnant.[58]

Hoang's work provides helpful insights into the complex sex industry in HCMC, especially the *class distinction* between the various sectors of sex workers and their clients. Women of the low-end sector are the poorest, and *therefore* the most vulnerable to HIV infection because of their very limited options and lack of access to the means to protect themselves. Operative within the cultural context is a very strong form of sexism, which further deprives Vietnamese women of the negotiating power in these sexual encounters. But the story of poverty and sexism predisposing Vietnamese women to HIV/AIDS does not end with these marginal women alone, as the story of T. related earlier in this section illustrates. The client at the brothel known as Khoa had family circumstances strikingly similar to T.'s story, which means that his wife and young son might also be at risk of HIV infection because of his behavior. In the mid-tier sector, women have more choices and resources to protect themselves, and are therefore less vulnerable to HIV infection. Nevertheless, the instability of the "relational exchanges," the number of clients the women form relationships with to ensure ongoing support, and

[57] Ibid, 272.

[58] Ibid, 393.

the way they express intimacy through unprotected sex means that both unplanned pregnancy and HIV risk are never far away. The work of accompaniment of the infected women by Fr. Phương Đình Toại provides examples of the risks these women are constantly exposed. Finally in the high-end sector, the fact that women of reasonable means, many with college degrees, engage in "intimate exchanges" with wealthy men in order to support their sophisticated lifestyle suggests a rising *classism* in the Vietnamese society. What brings wealthy overseas Vietnamese men to form temporary liaisons with women in this sector is often the desire for "traditional" women who are dependent and subordinate to them, while overseas women are often perceived as "too independent."[59] Again, *sexism* is never far from the surface even in this exclusive high-end sector. As Nguyen-Vo points out, Vietnam's market economy has significantly increased economic inequality, and this inequality is also reflected in sex work.[60] In addition, Hoang also contends that "globalization creates diverse markets and new segments that expand already existing inequalities" in this "emergent international city."[61]

Cahill has good reasons to maintain that women are more vulnerable to HIV because they are more poor, both materially and socially.[62] The low status of women in Vietnamese society significantly limits their access to social goods and their freedom to make choices about their own destiny. Women are often kept in the dark, or have no say in the sexual liaisons of their husbands. Once they are infected, many are cast out, as the

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[59] Ibid, 391.

[60] Nguyen-Vo, Thu-Huong, *The Ironies of Freedom Sex, Culture, and Neoliberal Governance in Vietnam* (Seattle: University of Washington Press, 2008).

[61] Hoang, "'She's Not a Low-Class Dirty Girl!': Sex Work in Ho Chi Minh City, Vietnam," 370.

[62] Cahill, "AIDS, Justice, and the Common Good," 285.

story of K. illustrates. For this reason, long term HIV prevention must challenge the unequal power relation that makes Vietnamese women the preferential targets of HIV transmission. In this light, Cahill believes that Catholic social teaching "offers a framework of analysis that clarifies the mutual rights and responsibilities of members of local and global communities."[63] It highlights the right and duty of all to participate in the common good, and the preferential option for those most excluded from participation. Furthermore, the principles of the dignity of the human person, the awareness of structural sin, and the principle of subsidiarity also point toward a community-based response that fosters networks of collaboration and accountability.

Writing from a Vietnamese perspective, theological ethicist Y-Lan Tran points out that Vietnamese cultural heritage presents both challenges and opportunities for the integration of Christian values.[64] Vietnamese culture highlights the indispensable role of mothers in bringing about happiness for the family and in the education of children. For this reason, it can provide support for social initiatives toward the more just remuneration for women's work. On the other hand, Christianity ought to have a corrective role in regard to the gender inequality promoted by Confucianism which limits the choices of girls and women.[65] Ms Nguyễn Thị Oanh, the renowned educator in public health and community development identified HIV/AIDS as an issue of *social development*.[66] The

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[63] Ibid, 286.

[64] Y-Lan Tran, "HIV/AIDS in Vietnam," 33-34.

[65] Tran also discusses the complex issues of violence, crimes, drug use and prostitution in young Vietnamese which are linked to poverty, ignorance, and the breakdown of traditional family structures. She also calls for the formal lifting of the ban on condom use. See ibid, 35-37.

[66] Nguyễn Thị Oanh, *Người Công Giáo Trước Đại Dịch HIV/AIDS*, [Catholics Facing the AIDS Pandemic] (TP HCM: Phòng Phát Triển Xã Hội Nhà Thờ Chánh Tòa Đức Bà, 2003), 8.

late Catholic community leader also stressed that the level of development of a society is a key factor in determining the outcome of the society's response to AIDS. Nguyễn saw the way the disease was quickly identified and contained in developed countries through the use of effective means of communication and education which helped change people's attitude and behavior as an example of good public health management. On this basis, Nguyễn proposed an action plan for the Catholic Church of Vietnam. She maintained that an effective response cannot be simply hand-out charity, but an active engagement with those infected with the virus, in ways that help overcome societal prejudice and exclusion from the community. Most importantly, Nguyễn called for a social solidarity, through local voluntary associations in the neighborhood, church groups, health alliance, and other forms of association. Above all, Nguyễn called for special attention to women and children, the two most disadvantaged target groups.[67]

Admittedly, there is still much to be done in regard to the social factors that are closely linked with the disease. The existing unjust structures that continue to predispose persons – especially women and children – to HIV infection remain a challenge for Vietnam's Catholic Church. In her insightful article, Y-Lan Tran describes the Vietnamese Church as a Church "burdened by threats" and has very limited influence in regard to human rights issues.[68] Nevertheless, Tran stresses the role of the Church to educate the faithful in Christian values, including those that are relevant for HIV prevention: sexual abstinence, fidelity, virginity, and the value of family life. At times,

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[67] Ibid., 14.

[68] Y-Lan Tran, "Vietnam in Transition: Theological and Ethical Challenges" in Agnes M. Brazal, Aloysius Lopez Cartegenas, Eric Marcelo O. Genilo, James F. Keenan (eds), *Transformative Theological Ethics: East Asian Contexts*, (Quezon City : Ateneo de Manila University Press, 2010), 43-68.

the Church is also called to take a prophetic role, as archbishop Joseph Ngô Quang Kiệt has shown an example in his defense of religious freedom in Vietnam.[69] Luke's vision of God's gift of salvation, of which physical healing is a part, invites Christians to confront the economic and social structures that dehumanize persons and expose them to HIV/AIDS and other forms of destitution.[70] Pope John Paul II in his 1987 encyclical *Sollicitudo Rei Socialis* reminds us that the condemnation of structures of sin and their associated forms of idolatry is part of the Church's ministry of evangelization in the social sphere, which is an aspect of the Church's prophetic role.[71] According to John Paul II, authentic human development demands structural reforms, as well as global solidarity and cooperation so that the fact of human interdependence is not used to further exploit the vulnerable in our world. In this light, though there is still much to be done, I believe that Vietnam's Catholic health workers are showing the first decisive step toward addressing these root causes of poverty and vulnerability to illness.

Before ending this Chapter, let us return to a theoretical question on the nature of the healing community that was raised in my introduction, prompted by the more recent works of Lisa Cahill in the light of the AIDS pandemic.

5.5. COMMUNITY AND PRACTICE IN VIRTUE ETHICS

Since Alasdair MacIntyre's influential work *After Virtue* (1981), more attention has been paid to the role of the community and the practices in the cultivation and transmission of

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[69] Ibid, 45-46.

[70] Brendan Byrne, *The Hospitality of God: A Reading of Luke's Gospel*, 195.

[71] Pope John Paul II, *Sollicitudo Rei Socialis*, Vatican, 1987, par. 37, 41.

virtues. When applying these concepts to medical ethics, Pellegrino and Thomasma identify the medical profession as the community in view. This community consists of physicians, who share a practice which is the medical art, and who hold themselves bound by certain ethical standards appropriate for their profession. Medical practice is the means by which the virtues are cultivated and transmitted by practitioners from one generation to the next. While the authors' claim has certain validity in regard to the moral character and virtues that are fitting for physicians, the concepts of community and practice need to be enlarged beyond the bounds of the medical profession and their work, especially in the context of the fight against the AIDS pandemic. Cahill rightly points out that the global AIDS crisis has exposed the inadequacies of approaches to health ethics that ignore the social determinants of health and illness, such as poverty and sexism.[72] Cahill proposes a participatory model of bioethics that highlights the significance of teamwork, community projects and social action on behalf of the poor and disadvantaged. This involves broader conceptions of community, beyond the bounds of the physician-patient relationship, to include all persons involved in patient care. I argue for a synthesis of two conceptions of *community*: the exclusive view presented by Pellegrino and Thomasma, and the inclusive view proposed by Cahill, because each one has its own validity. With this synthesis, physicians have a distinctive specialized role within the health care community which is defined by its shared commitment to the health of patients. As discussed in my Chapter One, the medical profession is defined by its commitment to health, which is one of the intrinsic human goods that we need to live a

[72] See further discussion on pages 28-29. Lisa Sowle Cahill, *Bioethics and the Common Good*, (Milwaukee: Marquette University Press, 2004); *Theological Bioethics: Participation, Justice, and Change,* (Washington, D.C.: Georgetown University Press, 2005).

humanly flourishing life.[73] This commitment determines both the physician's role and the medical virtues that enable physicians to meet the goal of serving the health of patients.[74] The AIDS pandemic presents us with very complex and diverse aspects of patient care that demand nothing short of a team response with participation from many persons who have different roles and capacities to make health care possible. The community-based model of care adopted by Vietnam's Catholic AIDS care network is a good illustration of this point. Each health care team described in this Chapter consists of non-medical and medical persons, who form a community with a shared commitment to the health of AIDS patients. Within this community, physicians such as surgeon Dr. Nguyễn Đăng Phấn and Fr. Nguyễn Viết Chung, M.D. are part of a sub-community that has a crucial role in patient care, while allied health professionals, community health workers, educators, pastors, family members and support persons of those living with HIV/AIDS also have indispensable roles to play. When it comes to the specific practices, and the goals which give rise to specific virtues in health care, it is necessary to identify what are peculiar to the medical profession, as Pellegrino and Thomasma do. Medical consultations, diagnostics, and treatment are practices traditionally connected with the medical profession, and the means by which the medical virtues are exercised and cultivated. However, physicians can be considered a sub-community which is distinctive but not separated from the health care community.

Furthermore, in light of the current awareness of the social determinants of health and

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[73] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, 75.

[74] Ibid, 92-93. Oakley and Cocking suggest (without explaining in detail) their own list of medical virtues which includes beneficence [sic], truthfulness, trustworthiness, courage, humility, and justice.

illness, effective HIV prevention requires a broader concept of community, which is defined by a common goal, and not necessarily by a common professional training. Because the AIDS virus has its own preferential option for the poor, the fight against this pandemic must address the root causes of this disease: poverty, gender inequality, classism, homophobia and other forms of social injustice. This involves medical and non-medical individuals and organizations that are bound together to fight this deadly virus. As the examples Dr Nguyễn Đăng Phấn have shown, doctors have a very significant leadership role to play within this inclusive community, for they can provide their expertise for the training of community health care workers, provide moral support and medical support, and exercise considerable authority in advocacy, in health promotion, in care and prevention because of their moral integrity and their commitment to the common good. In this context, Cahill draws upon Catholic social teachings and the works of Jacques Maritain and argues that the community ought to include the whole city, the nation, the region, and the globe.[75] The fight against the AIDS pandemic calls for the engagement of broader categories of participants and networks of association in the common project on behalf of the most vulnerable in society.

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[75] Lisa Sowle Cahill, *Theological Bioethics : Participation, Justice, and Change,* (Washington, D.C.: Georgetown University Press, 2005; *Bioethics and the Common Good*, (Milwaukee: Marquette University Press, 2004). Arguably, being part of this global community, each of us has the responsibility toward others who are suffering injustice and dehumanization because of disease and poverty. The Catholic Relief Services suggest practical ways to advocate for continued funding for PEPFAR with Congress. See. http://crs.org/public-policy/hiv_aids.cfm.

5.6. CONCLUSION

In the context of the AIDS pandemic, the human society is often tempted to fear and to despair, while it tries to protect itself by excluding those whose lives are in turmoil. For this reason, Vietnam's Catholic AIDS care network is a powerful witness to Christian love, which is shaped by Luke's healing narratives and the Good Samaritan story. The practices of these healing communities embody the virtues of mercy, compassion, hospitality, and solidarity of Jesus in Luke's healing narratives. Their works highlight the connections between personal virtues, the community that bears witness to Christ the healer, and social action on behalf of the most disadvantaged in society. They also reflect the crucial aspects of Lãn Ông's view of medicine as the art of humaneness, especially his emphasis on the value of human lives, and concern for the poor and vulnerable in society. In the face of widespread public aversion and paralysis when confronted with the AIDS crisis, I believe the most significant *social contribution* of the Catholic AIDS care network is the leadership it has provided in the fight against this deadly virus. Catholic health workers have not only provided much needed health and social services to infected persons and their families, but also shown that care for AIDS patients is possible, and that much can be done to assist infected individuals. In addition, Catholic health workers also help society to take the first step toward HIV prevention by changing public perception about the disease, overcoming the taboo associated with HIV/AIDS. Furthermore, Catholic health workers have also contributed directly to HIV prevention through education and empowerment of infected persons and their families toward harm reduction. There are however important societal determinants of vulnerability to HIV

that must be addressed, which include poverty, sexism, classism, homelessness, homophobia, urbanization and the breakdown of traditional support structures. The teachings and healings of Luke's Jesus can inspire and empower the Christian commitment to the care and defense of infected individuals and their families, and can also foster a solidarity for social change.

Conclusion

VIRTUE-BASED MEDICAL ETHICS, LUKE, AND LÃN ÔNG

The Nuremberg trials ushered in a new era in which the four principles approach has become progressively the norm in Euro-American biomedical ethics, while the concepts of virtue and character become marginalized. In recent decades, the AIDS pandemic has highlighted the social aspects of health and illness, and the individualistic nature of the four principles approach proves inadequate in addressing the social causes of illness and poor health. At the global level, the promotion of the four principles approach as the universal norm can lead to the displacement of local values and customs, and the alienation of people from their cultural heritage. In this dissertation, I argue that although principles are indispensable, the virtue-based approach is more adequate in addressing these needs. As James Drane points out, and recent empirical research has also confirmed, the medical virtues enable health practitioners to perform their professional role well on a consistent basis. A virtue-based medical ethics informed by the gospel vision of healing can provide support for models of health care that take seriously the social determinants of illness, and advocate action on behalf of the poor and the marginalized. At the global level, virtue-based medical ethics also allows the coexistence of the universal values and the local norms, and encourages cross-cultural dialogue.

In this study, I argue that a very adequate philosophical framework for virtue-based medicine is the Aristotelian teleological structure, in which medicine is defined by its commitment to health, and medical virtues are personal excellences that help

physicians fulfill their role in the service of a patient's health on a consistent basis. Building on the Aristotelian teleological structure, I develop a theological medical ethics by integrating insights from selected healing narratives in Luke-Acts. In light of Yiu Sing Luke Chan's view that an integrated Scripture-based ethics requires both biblical scholarship and ethical hermeneutics, my dissertation provides a historical critical study of the selected Lukan texts, and integrates the theological insights retrieved from biblical texts into the Aristotelian structure of medical ethics. This work yields some important insights for Christian medical ethics. It demonstrates that Luke presents Jesus' healings through a distinctive theological lens that highlights the virtues of mercy and hospitality in Jesus. These virtues, which are connected with two key themes in Luke-Acts, have their origin in the Old Testament and refer primarily to God's saving action toward humanity. In Luke, Jesus' virtues of mercy and hospitality are shown especially in his outreach to the poor and the outcast of society. In parallel with the evolving theme of universality in Luke-Acts, there is also an expanding view of God's mercy and hospitality to all the nations through the ministry of Jesus and of the Church. My study also shows that the healing narratives in Luke-Acts are congruent with the teleological structure of virtue ethics and with the *imitation of Christ* motif. Not only does the evangelist see an exemplary pattern in Jesus' healings, he also provides accounts of Jesus' disciples performing healing acts in conformity with the examples set by Jesus the virtuous healer. Through the narrative structure of Luke-Acts and through his depiction of the role of the Holy Spirit, the evangelist stresses that the Church's mission is in fact a *continuation* of Jesus' earthly ministry. I believe that this continuation occurs at both the ethical level and the theological-spiritual level, both of which are significant for a virtue ethics

centered on the *imitation of Christ*. At the ethical level, the evangelist presents an exemplary pattern in Jesus' healings, which is replicated in the disciples' healing acts in the post-Easter era. At a deeper theological level, Luke presents Christian disciples being transformed interiorly by the Holy Spirit into the pattern of Jesus, so as to engage in the same mission of the earthly Jesus. Luke's theological perspective also makes Christian ethics part of the salvation history, precisely because Christian formation and praxis are oriented toward the *continuation* on earth of the presence and ministry of Jesus Christ.

Moreover, Jesus' double love command in Luke, which is illustrated by the Good Samaritan story, further highlights the exemplary nature of Jesus' healing acts. It also emphasizes the non-discriminatory love which Jesus embodies in his healing ministry, and links Christian love with concrete acts of mercy and hospitality in the service of the afflicted. The inclusive love that Jesus illustrates with this parable also reflects the evolving theme of universality in Luke-Acts. I believe that Luke's theological perspective has significant implications for Christian health care because it presents the Church's health ministry as a continuation of Jesus' earthly ministry. In this light, Christian health care ought to be in conformity with Jesus' outreach to the afflicted, the handicapped and the marginalized in the service of God's salvific purpose for humankind.

My study of Lãn Ông's texts in their historical and literary contexts demonstrates that Lãn Ông identified himself among the Confucianist physicians. His writings provide a coherent medical ethics that is grounded in the Confucianist tradition, and in continuity with the Chinese medical tradition. His *Moral Precepts for Physicians* both reiterates the

moral guidelines of earlier Chinese authors and develops them in a distinctive direction. Lãn Ông shows particular concern for the poor and the most vulnerable in society: the orphans, the widows and the childless elderly, and maintains that physicians ought to provide for them, out of their own resources, when their needs demand. More than other authors of the Confucianist tradition, Lãn Ông stresses the social responsibilities of physicians, whom he considers guardians of human lives. Because medicine is "the art of humaneness," Lãn Ông insists that practitioners ought to live up to this name by valuing human lives above profit, and by committing themselves to the service of patients, which often demands making sacrifices for those in dire need. Consistent with the Confucian theory of Rectification of Names, Lãn Ông maintains that physicians ought to fulfill their role by displaying competence and virtue in medical practice. Furthermore, by insisting that the physician practices the *dao* of medicine Lãn Ông links the physician's role with the good of society. In his view, in so far as physicians perform their role well, they can contribute positively to the harmony and flourishing of society by setting good examples of virtue and integrity for others.

There are strong similarities between the Lukan view of Christian love and Lãn Ông's understanding of *ren*, the basis his medical ethics. While *ren* in Confucianism denotes a universal and graded love in favor of those closest to oneself, Lãn Ông accents the universal and egalitarian aspects of *ren* in health care. This resonates with the non-discriminatory love which Luke's Jesus embodies in the healing narratives, and which Jesus teaches through the parable of the Good Samaritan. Furthermore, *ren* in Lãn Ông's medical ethics is the basis of both the professional duties and the social responsibilities of

physicians, especially in the care for the poor orphans, widows, and lone elderly in the community. This echoes Jesus' ministry to the poor and the social outcast in Luke. Lãn Ông's insistence that human lives ought to be valued above profits resonates with Luke's emphasis on personal conversion and the right attitude towards material possessions. Lãn Ông's references to reward and punishment for physician conduct also correlate with Jesus' teachings on mercy and apathy, and their consequences (Luke 10:25-37, 16:19-26). In this sense, virtue-based medical ethics allows the context-rich values and concepts in each tradition to surface, and promotes correlation of ideas and beliefs across cultures while preserving the distinctiveness of each.

The Catholic AIDS care network in Vietnam provides a good illustration of the connections between personal virtues, the formation of communities that bear witness to Christ the healer, and social action on behalf of the most disadvantaged in society. The practices of these healing communities embody the virtues of mercy, compassion, hospitality, and solidarity of Jesus in Luke's healing narratives. They also reflect the crucial aspects of Lãn Ông's view of medicine as the art of humaneness, especially his emphasis on the value of human lives, and concern for the poor and vulnerable in society. Their works on behalf of the afflicted through health services, education for harm reduction, accompaniment, advocacy, and the provision of shelter and support for AIDS sufferers also help illustrate the social dimension of virtue-based medicine. In as much as HIV/AIDS exposes the societal causes of poverty and illness, health practitioners are urged by Christian love and the virtue of justice to serve and to engage in social action on behalf of the most disadvantaged in society.

Within the Aristotelian teleological structure, medicine is defined by its commitment to health. The AIDS pandemic has highlighted the fact that people's health is at least partly determined by social factors, such that the least advantaged in society are also the most vulnerable to ill health and HIV infection. Virtue-based medical ethics, shaped by Luke's view of Christian love, not only urges physicians to fulfill their professional duties in patient care through the cultivation of personal virtues, but also calls them to reach out to the most vulnerable, and to engage in concrete action for a more just society.

Appendix I:

CHEN SHIH KUNG'S FIVE COMMANDMENTS FOR PHYSICIANS[1]

(*Yī jiā wǔ jiè* 醫家五戒 Y Gia Ngũ Giới)

5.1. Physicians should be ever ready to respond to any calls of patients, high or low, rich or poor. They should treat them equally and care not for financial reward. Thus their profession will become prosperous naturally day by day and conscience will remain intact.

5.2. Physicians may visit a lady, widow or nun only in the presence of an attendant but not alone.[2] The secret diseases of female patients should be examined with a right attitude, and should not be revealed to anybody, not even to the physician's own wife.

5.3. Physicians should not ask patients to send pearl, amber or other valuable substances to their home for preparing medicament. If necessary, patients should be instructed how to mix the prescriptions themselves in order to avoid suspicion. It is also not proper to admire things which patients possess.

5.4. Physicians should not leave the office for excursion and drinking. Patients should be examined punctually and personally. Prescriptions should be made according to the medical formulary, otherwise a dispute may arise.

5.5. Prostitutes should be treated just like patients from a good family and gratuitous services should not be given to the poor ones. Mocking should not be indulged for this brings loss of dignity. After examination physicians should leave the house immediately. If the case improves, drugs may be sent but physicians should not visit them again for lewd reward.

CHEN SHIH KUNG'S TEN REQUIREMENTS FOR PHYSICIANS

(*Yī jiā shí yào* 醫家十要 Y Gia Thập Yếu)

10.1. A physician or surgeon must first know the principles of the learned. He must study all the ancient standard medical books ceaselessly day and night, and understand them thoroughly so that the principles enlighten his eyes and are impressed on his heart. Then he will not make any mistake in the clinic.

10.2. Drugs must be carefully selected and prepared according to the refining process of

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[1] Translation by Tao Lee, "Medical Ethics in Ancient China" in Veatch, *Cross Cultural Perspectives in Medical Ethics: Readings*, 135-136. Note more details of explanation in Unschuld's translation of Ch'en Shih-kung, *Wai-k'o cheng-tsung*, ch 8, p. 125-128, in Li T'ao, "Chung-kuo ti i-hsueh tao-te-kuan," p. 271-3.

[2] Tao Lee believes this attitude has its origin in Mencius' teaching that "men and women, in giving and receiving, must not touch each other." Tao Lee, "Medical Ethics in Ancient China," 137.

Lei Kung. Remedies should be prepared according to the pharmaceutical formulae but may be altered to suit the patient's condition. Decoctions and powders should be freely made. Pills and distilled medicine should be prepared in advance. The older the plaster is the more effective it will be. Tampons become more effective on standing. Don't spare valuable drugs, their use is eventually advantageous.

10.3. A physician should not be arrogant and insult other physicians in the same district. He should be modest and careful towards his colleagues; respect his seniors, help his juniors, learn from his superiors and yield to the arrogant. Thus there will be no slander and hatred. Harmony will be esteemed by all.

10.4. The managing of a family is just like the curing of a disease. If the constitution of a man is not well cared for and becomes over-exhausted, diseases will attack him. Mild ones will weaken his physique, while serious ones may result in death. Similarly, if the foundation of the family is not firmly established and extravagance be indulged in, reserves will gradually drain away and poverty will come.

10.5. Man receives his fate from Heaven. He should not be ungrateful to the Heavenly decree. Professional gains should be approved by the conscience and conform to the Heavenly will. If the gain is made according to the Heavenly will, natural affinity takes place. If not, offspring will be condemned. Is it not better to make light of professional gain in order to avoid the evil retribution?

10.6. Gifts, except in the case of weddings, funerals and for the consolation of the sick, should be simple. One dish of fish and one of vegetable will suffice for a meal. This is not only to reduce expenses but also to save provisions. The virtue of a man lies not in grasping but rather in economy.

10.7. Medicine should be given free to the poor. Extra financial help should be extended to the destitute patients, if possible. Without food, medicine alone can not relieve the distress of a patient.

10.8. Savings should be invested in real estate but not in curios and unnecessary luxuries. The physician should also not join the drinking club and the gambling house which would hinder his practice. Hatred and slander can thus be avoided.

10.9. Office and dispensary should be fully equipped with necessary apparatus. The physician should improve his knowledge by studying medical books, old and new, and reading current publications. This really is the fundamental duty of a physician.

10.10. A physician should be ready to respond to the call of government officals with respect and sincerity. He should inform them the cause of the disease and prescribe accordingly. After healing he should not seek for a complimentary tablet or plead excuse for another's difficulty. A person who respects the law should not associate with officials.[3]

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[3] The warning to physicians against using their influence to speak on behalf of another person, lest it affect the official's impartiality of judgment on civil matters.

Appendix II

CHEN SHIH-KUNG'S FIVE COMMANDMENTS AND TEN REQUIREMENTS IN PARALLEL WITH LÃN ÔNG'S MORAL PRECEPTS FOR PHYSICIANS[4]

Chen Shih-kung	Lãn Ông
10.1. A physician or surgeon must first know the principles of the learned.	**1.** A learner of medicine must first master the principles of Confucianism. When one masters the principles of Confucianism, learning medicine becomes easy. During free time,
He must study all the ancient standard medical books ceaselessly day and night, and understand them thoroughly so that the principles enlighten his eyes and are impressed on his heart.	one ought to study carefully the famous medical books, ancient and new, studying hard to understand and integrate the knowledge. When one has taken [the knowledge] to heart, and seen clearly with one's eyes.
Then he will not make any mistake in the clinic.	One can then apply that knowledge to the hand without making mistakes.
5.1. Physicians should be	**2.** When asked to visit patients, one ought to give priority according to the urgency of patient illness.
ever ready to respond to any calls of patients, high or low, rich or poor. They should treat them equally and care not for financial reward.	Do not give priority [in your visits] according to people's wealth or social status, nor to dispense medicine differently according to social class.
Thus their profession will become prosperous naturally day by day and conscience will remain intact.	When your heart is tainted with dishonesty, it is hard to gain people's trust, or to achieve good results.

[4] In this table, Chen Shih-kung's *Five Commandments* are identified as 5.1, 5.2, …, 5.5, and his *Ten Requirements* are numbered 10.1, 10.2, …, 10.10. The table follows the order of Lãn Ông's *Moral Precepts* in the right column, with the corresponding precepts in Chen's texts shown at the same level on the left column. The table omits Chen's 10.4, 10.5, 10.6, 10.8, 10.9 which were left out in Lãn Ông's text.

Chen Shih-kung	Lãn Ông
5.2. Physicians may visit a lady, widow or nun only in the presence of an attendant but not alone. The secret diseases of female patients should be examined with a right attitude, and should not be revealed to anybody, not even to the physician's own wife.	**3.** When asked to examine women, widows or nuns the physician must have an attendant by his side, before entering the room for examination in order to avoid any suspicion; the same applies [when treating]
5.5. Prostitutes should be treated just like patients from a good family and gratuitous services should not be given to the poor ones. Mocking should not be indulged for this brings loss of dignity. After examination physicians should leave the house immediately. If the case improves, drugs may be sent but physicians should not visit them again for lewd reward.	female entertainers or prostitutes, the physician must strictly keep the purity of heart, treating them the same as he would treat women of reputable families. Avoid every form of flirtatious behavior or it would harm your reputation, or you would bear the result of sexual misconduct. **4.** A medical practitioner ought to think of serving others;
5.4. Physicians should not leave the office for excursion and drinking.	he cannot leave his practice for recreation, taking wine to the mountain, or sight seeing; [for in such case], if a patient needs your urgent assitance, people will be anxious waiting, while a human life is in grave danger. A physician must know how important his task is.
Patients should be examined punctually and personally. Prescriptions should be made according to the medical formulary, otherwise a dispute may arise. [**5.3.** If necessary, patients should be instructed how to mix the prescriptions themselves in order to avoid suspicion].	**5.** When the patient suffers from a grave illness, and you want to do all you can to restore the patient to health, though it is a beautiful desire, you must explicitly explain [the treatment] to the patient's family before giving the prescription; they will do what they can to get the medicine. If the medicine brings good results, you have their admiration. Even if the illness turns worse, there will be no complaints, and you will have a clear conscience.

Chen Shih-kung	Lãn Ông
[10.2. Don't spare valuable drugs, their use is eventually advantageous].	**6.** When buying medicinal herbs, one should select expensive items.
10.2. Drugs must be carefully selected and prepared according to the refining process of Lei Kung.	Closely study Lei Kung's apothecary methods, then prepare and preserve medicines appropriate for time and place.
Remedies should be prepared according to the pharmaceutical formulae but may be altered to suit the patient's condition.	At times one should follow exactly the existing formulae, at times modify it according to circumstances and the patient's illness.
	When creating a new formula, one must be directed by the sophisticated reasoning of ancient thinkers, and avoid callously creating new formulae to experiment on persons.
Decoctions and powders should be freely made. Pills and distilled medicine should be prepared in advance.	One should have at hand adequate amounts of medicinal herbs for decoction and medicine powder. Medicines in tablet forms and refined concentrated forms must be available in adequate amounts.
The older the plaster is the more effective it will be. Tampons become more effective on standing.	
	Being so prepared, one can provide for each patient in time, and not feel powerless when such needs arise.
10.3. A physician should not be arrogant and insult other physicians in the same district. He should be modest and careful towards his colleagues; respect his seniors, help his juniors, learn from his superiors and yield to the arrogant.	**7.** When meeting colleagues, one must be humble and courteous, careful not to despise or disrespect them. To the older physician, show respect. The learned, regard as one's teacher. To the arrogant, show humility and patience. To the poorly trained, give guidance.
Thus there will be no slander and hatred. Harmony will be esteemed by all.	Cultivating such a virtuous character can bring many blessings.

Chen Shih-kung	Lãn Ông
	8. When visiting patients from very poor families, the orphans, the widows, the childless elderly, the more one must make special efforts to provide care. For persons of wealth and status, you need not worry about their lack of medical care; but poor and lowly persons are unable to invite famed physicians. If one devote whole-heartedly to the person for a short time, his (or her) life will be saved. When very dutiful children, or very dedicated wives become sick because of extreme poverty,
10.7. Medicine should be given free to the poor. Extra financial help should be extended to the destitute patients, if possible. Without food, medicine alone can not relieve the distress of a patient.	besides giving free medicines, one should also provide for them according to one's means, for persons who have medicines but no food to eat also perish. One must care for the person's life in its totality to be worthy of the art of humaneness. Those who become poor and sick from reckless exploits do not deserve as much sympathy.
10.10. After healing he should not seek for a complimentary tablet.	**9.** After the patient is cured, one must not ask for lavish gifts in return, because recipients of [lavish] gifts often become subservient. Not to mention the fact that persons of wealth and status are often unpredictable in their attitude; those who seek glory [from them] often bear shame; those who try to please [them] for personal gain would reap unpleasant results. The healing art is a dignified art, the practitioner must cultivate a dignified character.

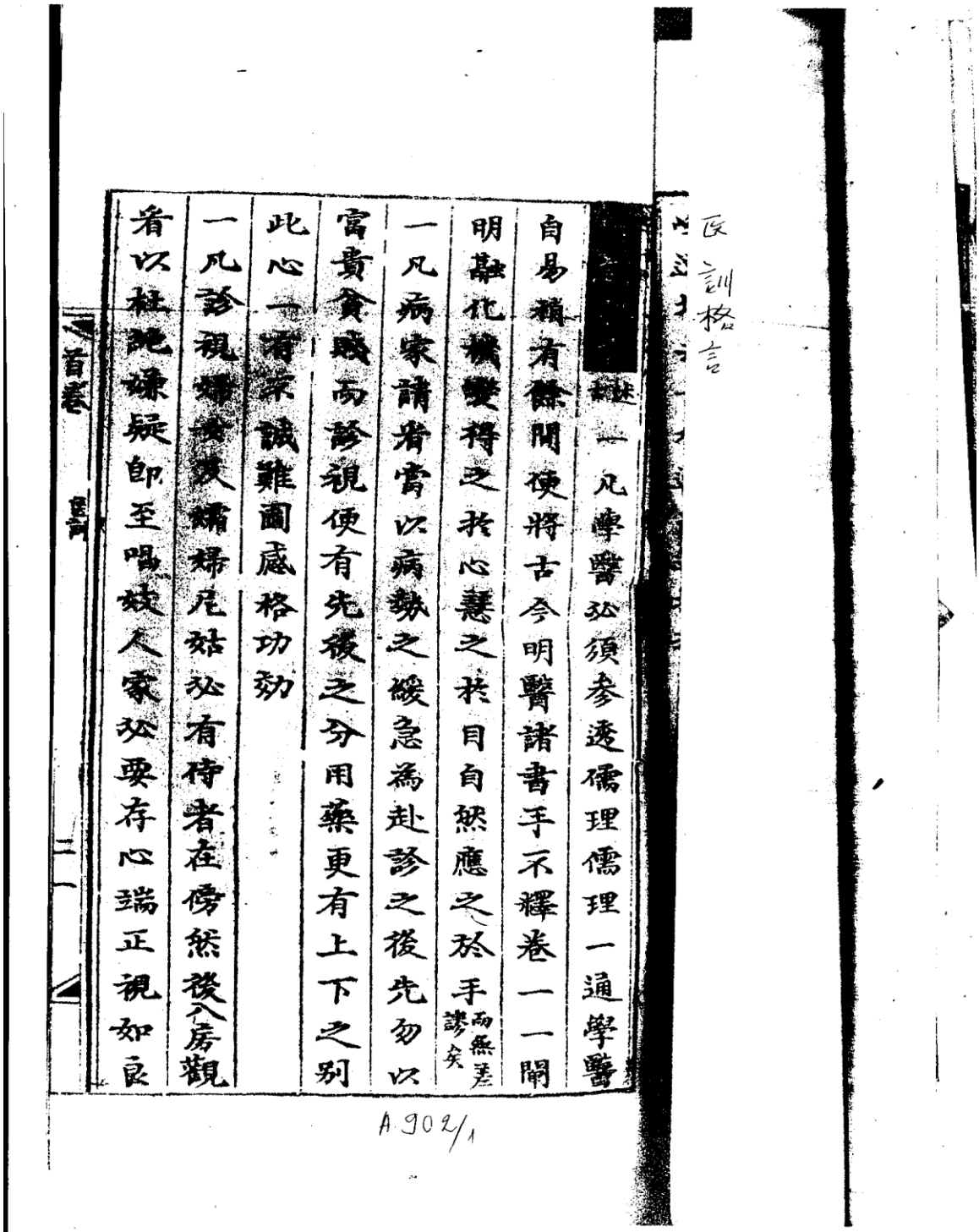
Appendix III

TIMELINE OF CHINESE AND VIETNAMESE HISTORY[5]

BCE CE	CHINESE DYNASTIES	CHINESE SCHOLARSHIP	VIETNAMESE DYNASTIES	VIETNAMESE SCHOLARSHIP
550	(Zhou Dynasty)	Confucius (551-479)	(Hồng Bàng 2879-258BCE)	
500	481 End of the *Chunqiu* Period	Mo Tzu (c. 479-c. 381)		
450				
400	403-221 Warring States Period	Mencius (372?- 289?)		
350		Lao Tzu (?)		
300	Qin Dynasty	Chuang Tzu (369?-286)		
250	(255-207)		Thục Dynasty (257-207BCE)	
200	Han Dynasty		Triệu Dynasty (207-111BCE)	
150	(206BCE-220CE)	Dong Zhongshu (179?-104?)	**Chinese Rule** (111 BCE - 931 CE)	Confucianism, Buddhism and Daoism came to Vietnam
100				
50			**Independence**	
CE				
900	Five Dynasties (907-959)	Sun Szu-miao (581?-682)	Ngô (939-956); Đinh (968-980); Early Lê (980-1009)	
1000	Song Dynasty (960-1279)	Lu Chih (754-805 CE)	Lý Dynasty (1010-1225)	
1100		Cheng Hao (1032-85)		Tuệ Tĩnh (1330-?)
1200	Yuan (Mongol) (1280-1367)	Cheng Yi (1033-1108)	Trần Dynasty (1225-1400)	Chu Văn An (?-1370)
1300		Zhu Xi (1130-1200)	Later Lê Dynasty (1428-1788)	Nguyễn Trãi (1380-1442)
1400	Ming (1368-1643)	Chang Kao (fl. 1210)	[Trịnh – Nguyễn Conflict]	
1500		Chu Hui-ming (ca 1590),	Tây Sơn (1788-1802)	
1600	Qing (1644-1911)	Chen Shih-kung (fl. 1605)	Nguyễn Dynasty (1802-1945)	Lê Quý Đôn (1726-1784)
1700			[French Presence 1874-1954]	Hải Thượng Lãn Ông (1724-1791)
1800				
1900	Republic (1912-)			

[5] This greatly simplified table draws upon Fung Yu-lan, *A History of Chinese Philosophy* (1973), and Trần Trọng Kim, *Việt Nam Sử Lược* [A Brief History of Vietnam] (1921). Names of physician authors are underlined for reference.

Appendix IV: Lãn Ông's Text of Moral Precepts for Physicians

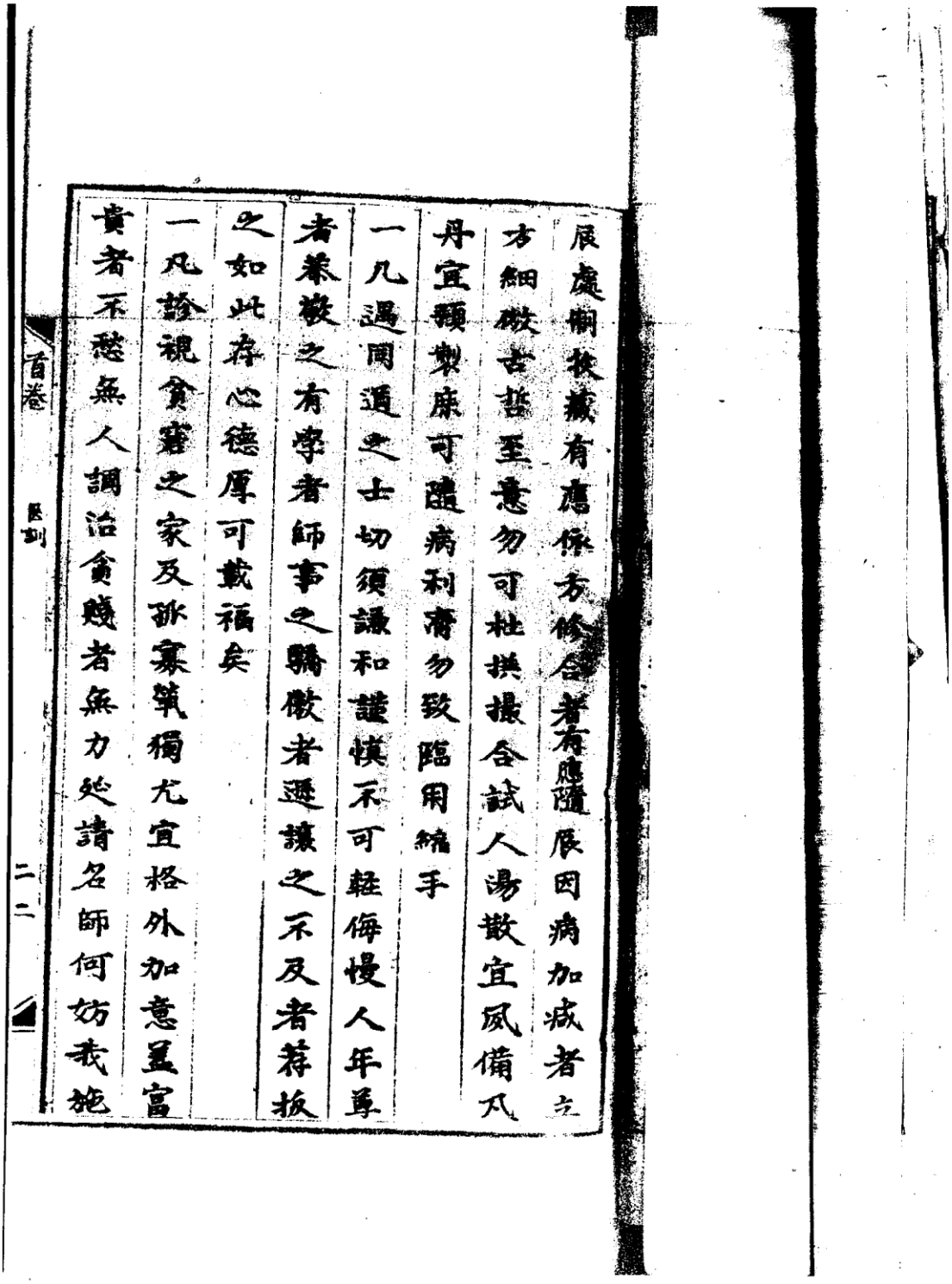


家子弟不可一毫兒戲以取不正之名必獲邪淫之報

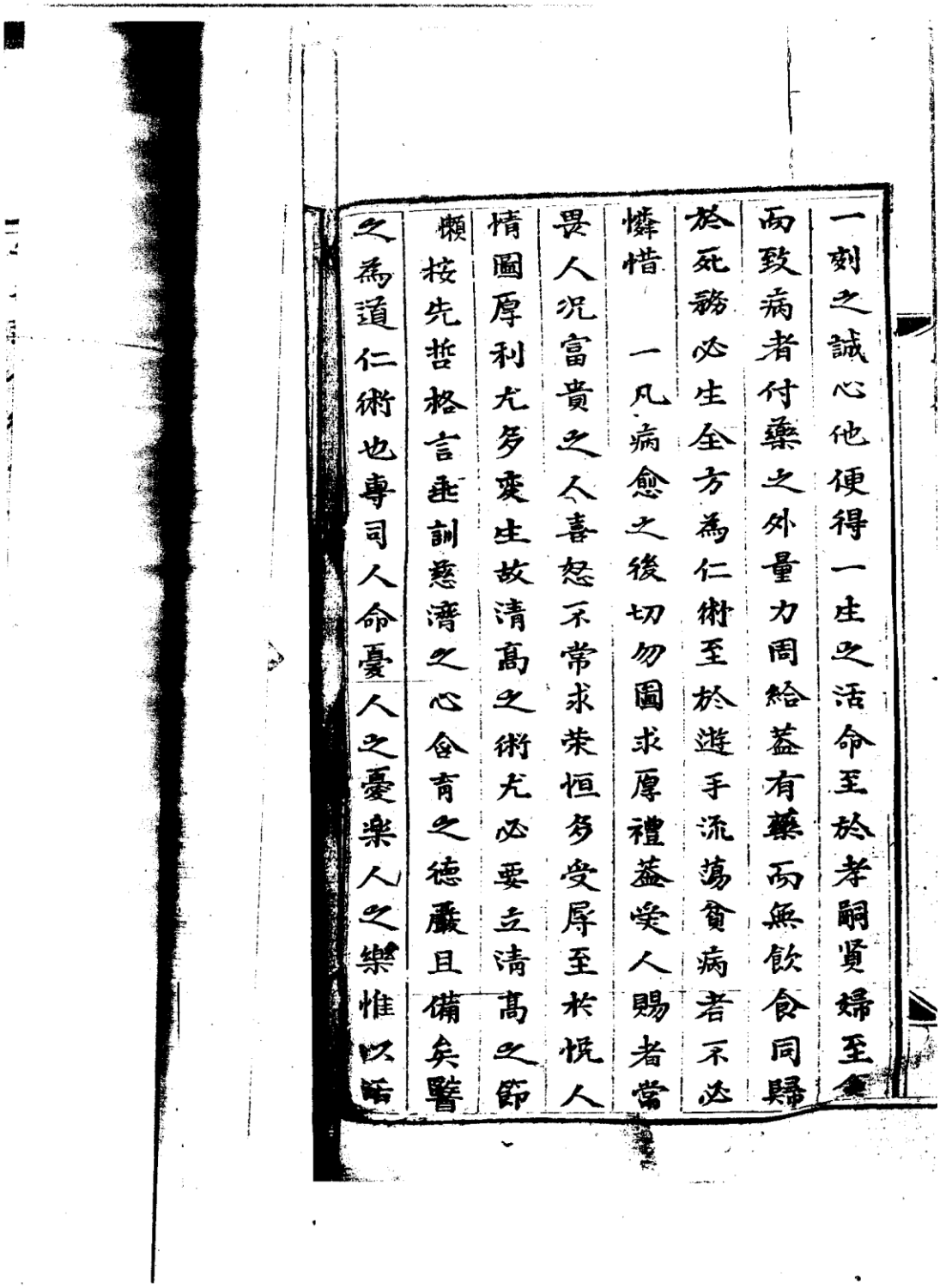
一凡醫者當以利物為念不可仁意行藥登山携酒迓玩岸辰離寓倘有暴病求援寧無負倒屣望救之恩誤人性命垂危之慘要知前司者何事

一凡遇危殆之症欲盡力挽回此雖美念然必須與病家講明方可下藥更必釐彼藥資則服藥有效尤自知感如服無效則疑怨雖加於我我亦自無愧矣

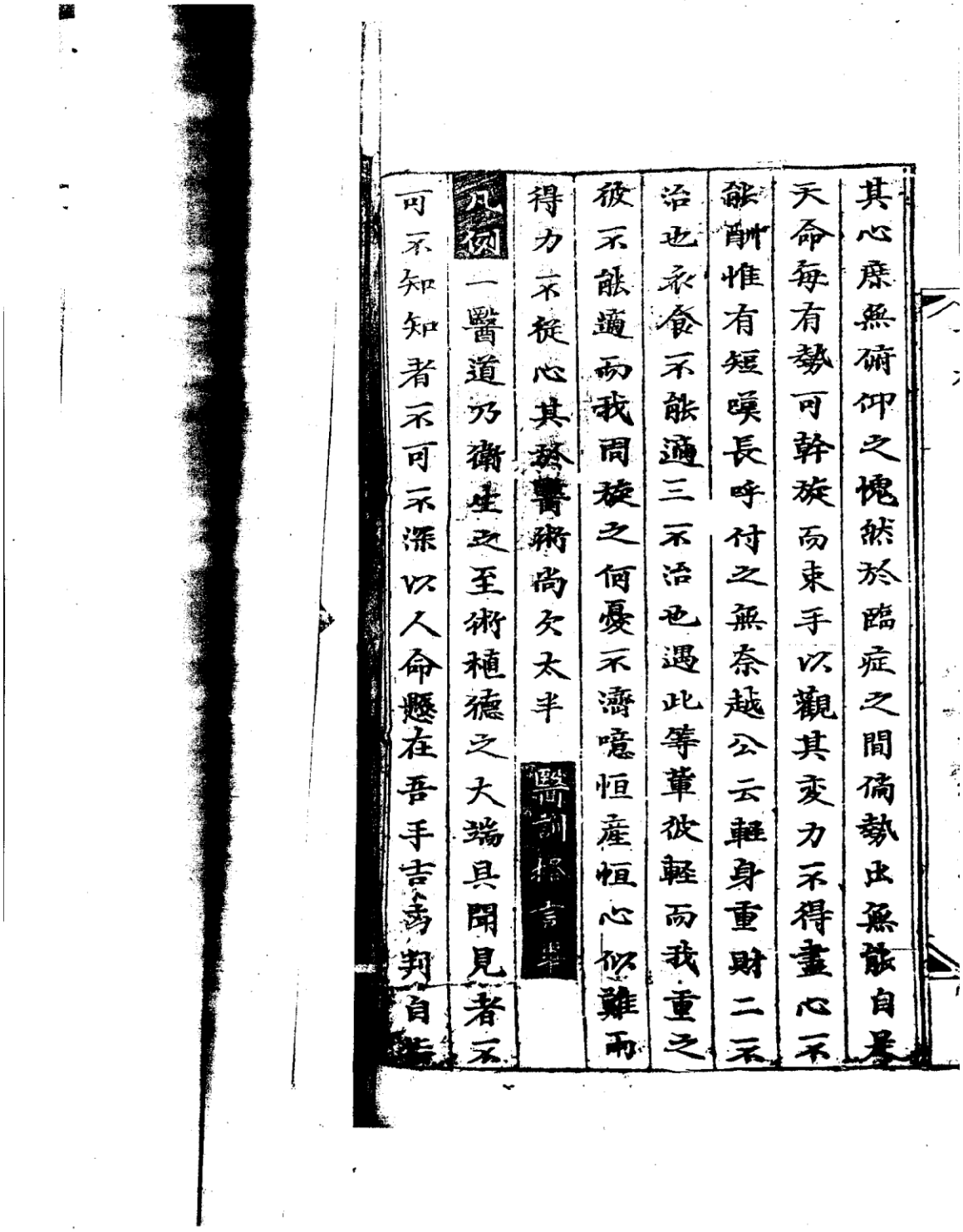
一凡置備藥材必須重價選買藥品謹察雷公立法



辰處倘秋藏有應係方修合者有應隨辰因病加減者亦
方細繳古哲至意勿可杜撰合試人湯散宜風備凡
丹宜預製庶可隨病利膏勿致臨用綿手
一凡遇同道之士切須謙和謹慎不可輕侮慢人年尊
者兼敬之有學者師事之驕傲者遜讓之不及者薦拔
之如此存心德厚可載福矣
一凡診視貧窘之家及孤寡築獨尤宜格外加意量富
貴者不慈無人調治貧賤者無力延請召師何妨義施



一刻之誠心他便得一生之活命至於孝嗣賢婦至
而致病者付藥之外量力周給蓋有藥而無飲食同歸
於死務必生全方為仁術至於遊手流蕩貪病者不必
憐惜　一凡病愈之後切勿圖求厚禮蓋受人賜者常
畏人況富貴之人喜怒不常求榮恒多受辱至於悅人
情圖厚利尤多變生故清高之術尤必要立清高之節
懶按先哲格言垂訓慈濟之心含育之德嚴且備矣醫
之為道仁術也專司人命憂人之憂樂人之樂惟以活



其心原無俯仰之愧然於臨症之間偏執出無能自是天命每有數可幹旋而束手以觀其變力不得盡心不能酬惟有短嘆長呼付之無奈越公云輕身重財二不治也衣食不能適三不治也遇此等輩彼輕而我重之彼不能適而我問旋之何憂不濟噫恒產恒心猶難而得力不從心其於醫術尚欠太半

醫訓摘言 半

凡例

一醫道乃衛生之至術積德之大端具開見者不可不知知者不可不深以人命懸在吾手吉禹判自

Appendix V: Plain Text of Lãn Ông's Moral Precepts for Physicians

醫訓格言

述古一凡學醫必須參透儒理儒理一通學醫
自易稍有餘閑便將古今名醫諸書手不釋卷一一闡
明融化機變得之於心慧之於目自然應之於手而無差謬矣
一凡病家請看當以病勢之緩急赴診之後先勿以
富貴貧賤而診視便有先後之分用藥更有上下之別
此心一有不誠難圖感格功效
一凡診視婦女及孀婦尼姑必有侍者在旁然後入房觀
看以杜絕嫌疑即至唱妓人家必要存心端正視如良

家子弟不可一毫兒戲以取不正之名必獲邪淫之報

一凡藝者當以利物為念不可任意行樂登山攜帶酒遊玩片辰離寓倘有暴病求援寧無負倒懸望救之恩誤人性命垂危之慘要知弥司者何事

一凡遇危迫之症欲盡力挽回此雖美念然必須與病家講明方可下藥更必盤彼藥資則服藥有畝人自知感如服無數則疑怨難加於我亦自無愧矣

一凡置備藥材必須重價選買藥品謹察雷公立法

辰處制後藏有應依方修合者有應隨辰因病加減者立方細微古哲至意不可杜撰撮合試人湯散宜夙備丸丹宜顆製庶可隨病利濟勿至臨用縮手

一凡遇同道之士切須謙和謹慎不可輕辱慢人年尊者恭敬之有學者師事之驕傲者遜讓之不及者荐扳之如此存心德厚可載福也

一凡診視貧窘之家及孤寡煢獨尤其格外加意蓋富貴者不愁無人調治貧賤者無力延請名醫何妨我施

一刻之誠心他便得一生之活命至於孝嗣賢婦至之而致病者付藥之外量力周給蓋有藥而無飲食同歸於死務必生全方為仁術至於遊手流蕩貧病者不必憐惜一凡病愈之後切勿圖求厚禮蓋受人賜者當畏人況富貴之人喜怒不常求榮恆多受辱至於悅人情圖厚利尤多變生故清高之術尤必要立清高之節

懶按先哲格言昭訓慈濟之心含育之德嚴且備矣醫之為道仁術也專司人命憂人之憂樂人之樂惟以諾

人爲分内事不可圖利計功雖無陽報自有陰隲誘云三世為醫後世必有卿相豈非培植之有自耶每見世醫或乘人父母之驚危或厄人雨夜之困急易者云難治難者云不治詭端以售管求立心既不良也用於膏織者則熱念以圖其利欲用於蓬華者則冷然而箴甚眾生嘆乎以仁術為福輪之術以仁心為市井之心陽責陰誅無能議矣懶絕志功名敵情云水古人云不為良相亦不失為良醫故思馨其所當為深其博濟以析

其心庶無俯仰之愧然於臨症之間倘勢出無能自若天命每有勢可幹旋而束手以觀其变力不得盡心不能酬惟有短嘆長乎付之無秦越公云輕身重財二不治也衣食不能適三不治也遇此等輩彼輕而我重之彼不能適而我問旋之何憂不濟噫恆產恆心似難而得力不從心其於醫術尚欠太半醫訓格言

凡例：一醫道乃衛生之至術植德之大端具聞見者不可知知者不可不深以人命懸在吾手吉凶判自

GLOSSARY

This glossary lists names, terms and phrases in the order that they appear in the Chapters. The names of books or texts are in italics.

Wade–Giles	**Pinyin**	**Traditional Chinese**	**Vietnamese**	**English**
Lao-Tzu	Laozi	老子	Lão Tử	[proper name]
Tao Te Ching	*Dao De Jing*	道德經	*Đạo Đức Kinh*	[name of work]
Chuang Tzu	Zhuangzi	莊子	Trang Tử	[proper name]
Nan Hua Ching	*Nan Hua Jing*	南華經	*Nam Hoa Kinh*	[name of work]
wu-wei	wu wei	無為	vô vi	non-action
san chiao t'ong yuan	sān jiào tóng yuán	三教同元	tam giáo đồng nguyên	Three religions share one root
Chang Tsai	Zhang Zai	張載	Trương Tái	[proper name]
Ch'eng Hao	Cheng Hao	程顥	Trình Hạo	[proper name]
Ch'eng I	Cheng Yi	程頤	Trình Di	[proper name]
Chu Hsi	Zhu Xi	朱熹	Chu Hi	[proper name]
ch'i	qì	氣	khí	substance, air, ether, energy
hsing	xing	性	tính	nature
li	lǐ	理	lý	principle, reason
wu-hsing shuo	wǔ-xíng shuō	五行說	thuyết ngũ hành	Theory of Five Elements
T'ien jen ho-i	Tiān rén hé yī	天人合一	Thiên nhân hợp nhất	Theory of the Unity of Heaven and Man
Sun Szu-miao	Sūn Sī miǎo	孫思邈	Tôn Tư Mạo	[proper name]
Pei-chi ch'ien-chin yao-fang	*Bèi jí qiān jīn yào fāng*	備急千金要方	*Bí kíp thiên kim yếu phương*	*Essential Remedies Worth a Thousand Gold*

				Pieces
Lun Ta-i Ching-Ch'eng	*Lùn dà yī jīng chéng*	論大醫精誠	*Luận Đại Y Tinh Thành*	*On the Absolute Sincerity of the Great Physician*
chung shu	zhong shu	忠恕	trung thứ	loyalty and reciprocity
Ju-i	Rú-yi	儒醫	Nho-y	Confucianist physician
Lu Chih	Lù zhì	陸贄	Lục Chí	[proper name]
chin-shih	jìn shì	進士	tiến-sĩ	doctorate
jen-shu	Rén-shù	仁術	nhân thuật	practiced humaneness; the art of humaneness
Chang Kao	Zhāng Guǒ	張果	Trương Quả	[proper name]
I-shuo	*Yī shuō*	醫說	*Y thuyết*	*Theory of Medicine*
yung-i	yōng yī	庸醫	dung y	Common physician
I-kung pao-ying	*Yī gōng bào yìng*	醫功報應	*Y công báo ứng*	*Retributions for Physician Conduct*
Chu Hui-ming	Zhū Huì-míng	朱惠明	Chu Huệ Minh	[proper name]
Tou-chen ch'uan-hsin lu	*Dòu zhěn chuán xīn lù*	痘疹傳心錄	*Đậu chẩn truyền tâm lục*	On the Diagnosis and Treatment of Smallpox
Kung Hsin	Gong Xìn	龔信	Cung Tín	[proper name]
Ku-chin t'u-shu chi-ch'eng	*Gǔjīn Túshū Jíchéng*	古今圖書集成	*Cổ kim đồ thư tập thành*	*Collection of Illustrations and Texts from*

				Ancient to Current Times
t'ai-i yuan	tài yī yuàn	太醫院	thái y viện	The Royal Medical Institute
ming-i	ming-yi	明醫	minh y	enlightened physicians
Kung T'ing-hsien	Gong Tíng-xián	龔廷賢	Cung Đình Hiền	[proper name]
Wan-ping hui-ch'un	*Wàn bìng huí chūn*	萬病回春	*Vạn bệnh hồi xuân*	*Ten Thousand Cures and Rejuvenation*
Chen Shih-kung	Chén Shí Gōng	陳實功	Trần Thực Công	[proper name]
Wai-k'o cheng-tsung	*Wài kē zhèng zōng*	外科正宗	*Ngoại Khoa Chính Tông*	*Orthodox Manual of Surgery*
I-chia Wu Chieh	*Yī jiā wǔ jiè*	醫家五戒	*Y Gia Ngũ Giới*	*Five Commandments of Physicians*
I-chia Shih Yao	*Yī jiā shí yào*	醫家十要	*Y Gia Thập Yếu*	*Ten Requirements of Physicians*
Ju-li	Rú lǐ	儒理	Nho lý	Principles of Confucianism
I hsun ko-yen	*Yī xùn gé-yán*	醫訓格言	*Y Huấn Cách Ngôn*	*Moral Precepts for Physicians*
I-yang an	*Yī yáng àn*	醫陽案	*Y Dương Án*	*Cases Successfully Treated*
I-yin an	*Yī yīn àn*	醫陰案	*Y Âm Án*	*Cases that Resulted in Death*
Chang Lu	Zhāng Lù	張璐	Trương Lộ	[proper name]
Ju-hsueh	Rú xué	儒學	Nho học	Confucianist learning

Cheng ming	Zhèng míng	正名	Chính danh	Theory of the Rectification of Names
Ch'eng	chéng	誠	thành	sincerity
i-tao	yī dào	醫道	y đạo	the *dao* of medicine
Yang Chu	*Yáng Zhū*	楊朱	Dương Chu	[proper name]
Ai yu ch'a teng	ài yǒu chà děng	愛有差等	ái hữu sai đẳng	love with distinctions
chih	zhi	直	trực	uprightness
T'ien-chu shih-i *(T'ien-hsueh shih-i)*	*Tiān Zhǔ shí yì* *(Tiān xué shí yì)*	天主實義 (天學實義)	*Thiên Chúa Thực Nghĩa* *(Thiên Học Thực Nghĩa)*	*The True Meaning of the Lord of Heaven* (*True Doctrine of Tian's Teachings*)
T'ai-p'ing-ching	*Tai-ping Jing*	太平經	*Thái Bình Kinh*	*Sutra on the Great Peace*
ch'eng-fu	chéng-fù	承負	thừa phụ	transmission of burden
Hsi Ch'ao	Xi Chao	郗超	Sĩ Siêu	[Proper name]
Feng-fa-yao	*Fèng fǎ yào*	奉法要	*Phụng Pháp Yếu*	*The Essentials of the Dharma*

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